GUY'S HOSPITAL GAZETTE
February 1992

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GUY'S HOSPITAL MEDICAL

- The Residents' Play—reviewed by Dr Rees
- Marathon '92—how to maximize pose value
- Tam O'Shanter—Robert Burns translated

Shepherds House—cleaning work in progress

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Guy's Gazette

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Passim

Welcome to the first *Gazette* of 1992. This is to be the year of the single European market, but not the year for a new front cover. Most of the comments have been very favourable regarding the current cover design, so I am not about to change it. As the sighs of relief subside, it is only fair to say that there may be some changes in the design and content in the coming months.

We have used the break afforded by not having a January issue to get back to a more reasonable publication date near the start of each month. This issue has, in fact, been painstakingly produced twice—once in the conventional manner, and again with computerised page layout here at the *Gazette* office. When the transition is complete, the *Gazette* should benefit from being able to accept material nearer publication, but sadly, contrary to our expectations, it doesn't look like being a labour-reducing exercise.

The closing stages of last year saw much enthusiastic and creative activity in the life at Guy's; the successful outcomes of Moonlite, Arsenic and Old Lace, the Residents' Play, Diwali Show and the 407 Art Club exhibition are a testament to that. Given all these positive ventures, it is disappointing to report on the introduction of railings at either end of the Colonnade. Their exact purpose remains quite obscure to me, and I might add, to others I have spoken to. The steps themselves are not particularly steep, nor can they be said to be numerous. I cannot imagine that they present the biggest obstacle to the elderly and infirm, especially considering the possible routes to Guy's from London Bridge station. Furthermore, the railings have served to spoil the only possible location for a year photograph. The powers that be seem determined to frustrate this annual event—first with the amalgamation, so that the medical school steps proved insufficient to accommodate the larger numbers, and now with railings! On a more positive note, it is nice to see that the work of cleaning up Shepherds House is well under way. How much more pleasant it will be to walk through the Park when the buildings are restored to their original colours.

The Spit has yet again become a topic of heated discussion amongst students. In this issue, Cedric Bore maligns the high prices charged, and rightly so. As someone who has recently come from Greenwich, and before that Lewisham, the value for money offered in the Spit seems most unreasonable. There was a time when buying lunch at A Piece of Cake was considered extravagant, but now it almost seems good value.

Finally, best wishes to the second years for their forthcoming exams—make sure you pass so that you too can work at Greenwich and Lewisham and see how canteens should be run!

Debasing Harley Street

Dear Sir,
I would not say for one moment that Harley Street is immune from charlatans and financial sharks. However, I feel that Dr David Stafford-Clark (whom I presume is hiding behind the initials D S-C) is confusing two things when he implies that non-medically qualified persons such as chiropractors, naturopaths, psychotherapists etc debase Harley Street because they are not medically qualified.

Those of us on the traditional side of medical practice believe tremendous advances have been made in recent years across the whole spectrum of medical and surgical disciplines. We would be deluding ourselves however, if we believe standard practice holds all the answers to the multitude of symptomatic problems with which people today present and expect cured. Does D S-C mean to say therefore that because someone is not medically qualified he/she is not in a position to help patients with problems which traditional medicine may well have failed to resolve? For example, in his own practice, he may well have used the assistance of clinical psychologists, but they would probably not have been medically qualified and therefore would they have been seen to debase his practice? I think not.

What Harley Street does offer is a total range of standard and alternative medicines, some of which are very good and others of course singularly useless. To regard anyone who is not medically qualified as the equivalent of a charlatan and a seeker of gold cannot be allowed to pass unchallenged.

Another unmentioned reason why patients (particularly mine) like to visit Harley Street is that it gives them a chance to do some shopping!

Yours faithfully,

TIM COLTART
Department of Obstetrics & Gynaecology
Guy's Hospital

About Dr Odgers

Dear Sir,
The September issue of the *Gazette* contained an article entitled 'Working with Mr Jacobson: Life as a ward clerk in 1900.' No doubt many of your readers wondered about the identity of the young man who walked the wards of Guy's ninety years ago. This fascinating memoir was written by Dr PNB Odgers (1877-1958). After obtaining first-class honours in physiology at Oxford in 1898, he moved to Guys's, obtaining the Conjoint Diploma in 1902, the degree of BM, BCh (Oxon) in 1903, his FRCS in 1903, and his MCh (in those days acquired by examination) in 1904, an achievement which must fill the present day surgical trainee with astonishment. After resident appointments at Guy's, the Evelina and Great Ormond Street hospitals, he was appointed as Consultant Surgeon at Northampton, where he worked for some 20 years, except for the years 1914–18 when he served as a Major in the RAMC in France.

In 1925 Dr Odgers forsook surgery and joined the staff of the Anatomy Department at Oxford. During his years in the department he made valuable contributions in the field of embryology, for which he was awarded his Doctorate of Medicine, but his outstanding contribution during these

years was as a quiet, effective teacher, whom I and many others still remember with affection. Dr Odgers retired in 1945, and lived in St John's Wood until his death in 1958. His daughter, Jane, trained as a physiotherapist at Guy's, and his grandson, Robin Odgers, following in the family pattern, trained at Oxford and Guy's, qualifying in 1974.

Yours faithfully,

PROFESSOR L P LE QUESNE
8 Eton Villas
London
NW3 4SX

Questions answered

Dear Sir,
Can I respond to two of the items published in your October issue, one of which asks a question about which I was, in any event, going to write to the *Gazette*.

1) Life as a Junior Surgical Dresser:
Dr Pitt-Payne asks what happened to the Lampsen (the correct spelling is Lamson) tube system installed in New Guy's House. As he rightly surmises the effect of high deceleration on pathological specimens, combined with the number of near right angled bends which had, perforce, to be installed in the system resulted in many accidents and blockages within the tube itself. The clearing out of these blockages was an unpleasant experience, particularly when a backlog had built up! Our foreman plumber, Bill Love, remembers the agony of this only too well and, as a junior on-call administrator in those years, so do I.

Incidentally a large number of other hospitals around the world who installed this sytem have suffered from the same problem and abandoned the Lamson Tube.

2) 'The Guy's Crest', letter from Dr George Weston:
Dr Weston asks what has happened to the War Memorial Gates. The Park itself is the Hospital's main War Memorial. The War Memorial Arch was erected across the entrance of the Park after the First World War. It was unveiled in July, 1921 by the Duke of York (later King George VI). The names of those who died in the Second World War were added to the Arch in 1947, at which time the Park itself was replanted.

Unfortunately the size and height of the Arch, combined with the tight road turning circle, made it impossible for us to get present day vehicular traffic into the Park and the Arch was removed from this location in the early 1967 when preparatory work for the Tower started. I remember when we were commissioning Guy's House in 1964 that a furniture van full of beds was brought into the Park, just clearing the Arch. When off-loaded, however, and not weighted down by its load, it refused utterly to pass out through the Arch! The only solution; to let down its tyres and press-gang a quantity of hefty rugger players who were passing by to stand in the van while a perspiring driver inched it out to safety.

The good news is that, through the generosity of the Special Trustees, the Arch is to be re-erected as part of the new main entrance of the Hospital which will be formed with the Phase III development in 1993–94. This location (in front of the existing ante-natal clinic) will be very close to where it stood previously, and Guy's people, patients and visitors will pass by it or through it daily.

In addition, the Memorial Park itself is to be landscaped. Pavement lines will be altered, both to recognise habitual short

routes without damage to the grass, and to avoid walking through dead leaves and the unpleasant side effects of our bird life! New shrubs and small trees will be planted and new seating areas including a mound will be formed. At the same time the facade of Shepherds House will be washed down. This work will start shortly to be ready for enjoyment during the summer months.

Yours faithfully,

SANDRA M CARNALL
Projects Director
Conybeare House
Guy's Hospital

Double first?

Dear Sir,

I trained at Guy's 1939–43. In the early 1950s I was senior night sister at Ayr County Hospital—as it was then known.

These hospitals have been in the first group granted trust status in England and Scotland respectively. A 'double first' in Guy's?

Yours faithfully,

NANCY HENDERSON née IRVINE
31 Holbeck Avenue
Scarborough
West Yorkshire

The Todd Report

Dear Sir,

In my letter in your October issue, I referred to the 'cost incurred in attaining the present situation of the Royal Free Hospital' School of Medicine. I was of course writing of the consequences of the Todd Report (1968) recommendations, which involved large outlays of time and money by the London Medical Schools. May I, please, make it clear that I in no way implied criticism of the Royal Free itself which I believe behaved with total integrity in its difficult situation. The money used to try to implement the proposed adjustments to the teaching of medicine in London could be employed in better ways.

Yours faithfully,

G A D HASLEWOOD
28 Old Fort Road
Shoreham-by-Sea
Sussex

Learning from travel

Dear Sir,

I am sorry that Mr Thompson (*Gazette*, November 1991) had to be divested of his appendix while on holiday in Czechoslovakia. It is even more of a shame that no legally acceptable surgical treatment exists for the mindless xenophobia which he sadly displays. His unedifying account of his experiences serves merely to demonstrate his contempt for the medical care which he received, and his ignorance of the country and its people.

Some people are perhaps unable to benefit much from the experience of travel. On the evidence of his article, Mr Thompson would, I expect, in future be best advised to stay at home.

Yours faithfully,

MARTIN STEFAN
41 Telford House
Tiverton Street
London

Naming names

Dear Sir,

I have very much enjoyed the reminiscences of Dr Pitt-Payne, whom I remember well as a student, and have been impressed by his power of recall.

However, at the risk of being considered a nit-picker, I would point out two inaccuracies which appeared in rapid succession in the third paragraph of his offering, 'Obs and Gobs in 1968' (November issue).

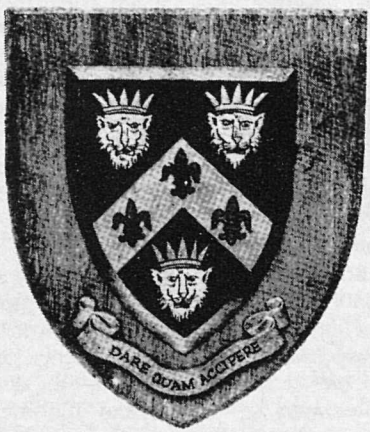
The reassuring man mentioned first, a famous Guy's Clinical Superintendent, was JB (not JA) Blaikley, while the lightning caesarian section operator spells his name 'Tomkinson' without a 'p'.

The errors may of course have been the result of proof reading fatigue; as an ex-editor of the *Gazette* I still remember the hours spent on this task. Or perhaps they were deliberate—Dr Pitt-Payne was 'just testing'. I wouldn't put it past him!

Yours faithfully,

J M HALL
27 Shirley Hills Road
Addington
Surrey

Guy's Hospital Gazette



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NHS—record complaints

More patients are complaining about the NHS, than ever before, with an increase in the number of complaints of 9.2% on last year's record figure. The NHS ombudsman explained that patients are now more aware of their right to complain. He added that the same problems keep cropping up; inadequate discharge procedures, cavalier attitudes and poor local investigation of complaints, showing that the NHS is not learning the lessons from previous reports.

Matron makes a return

By popular demand from patients, doctors and MPs, Guy's has reinstated the title of Matron for Wilma MacPherson, more formally known as director of nursing. Many see the demise of the matron figure as a root cause for the growing number of complaints about attitudes of nursing staff. Ms MacPherson explained that she took on the title to improve communications with patients, and that it does not denote any organisational change.

Guy's cash bonus

According to capital allocations and borrowing limits for all NHS trusts announced by the Government last month, Guy's will be able to spend nearly £36 million in new capital projects—three times more than any of the other 57 first wave trusts. Up to £20 million of this will be allocated to Guys in a grant because it is a teaching hospital.

Malcom Dennet, finance director of Guy's and Lewisham Trust, said the money would be spent on Phase III, a £118 million development which was approved before Guy's became a trust.

Overtime pay award

Junior doctors currently receive payments of 30–38% of their basic rate for work in excess of 40 hours a week. The Department of Health has revealed plans for three new bands to be introduced, with payments rising to between 50 and 100%. However the BMAs juniors' leaders said the award fell short of their demands, which were rates of between 60 and 120%, and that it failed to discriminate between doctors in different specialities. Industrial action in hospitals was not ruled out.

Central Research Fund

The Central Research Fund has been instituted for the purpose of making grants to members of the University (other than present undergraduate students and those registered for a taught Master's degree) engaged on specific projects of research, to assist with the provision of special materials, apparatus and travel costs. Applications are considered each term and the next closing date for applications is 22 March 1992. Forms of application and further particulars may be obtained from the Central Research Fund Section, Senate House, Room 21a, Malet Street, London WC1E 7HU. Tel (071) 636 8000 Ext 3147.

Legal abortions

Over three million abortions have now been carried out in England and Wales since the introduction of the Abortion Act in 1967, according to a report by the Office of Population Censuses and Surveys. The vast majority—2.7 million—were performed on residents, with foreigners accounting for 7%.

UMEG

UMEG, the United Medical Ethics Group, is set to start its third year as a forum for debate on issues in the field of medical ethics. The United Medical Ethics Group was established at Guy's and St Thomas's Hospitals in 1989 following the demise of the London Medical Group (the LMG). Events arranged by UMEG centre around the organisation of symposia which are open to everyone with an interest in health care, although medical and nursing students, as well as clinical staff usually form a large proportion of the audience.

Over the years topics for discussion have included neonatal intensive care, abortion, Aids, surgery for the transsexual, torture, the dying patient, organ transplantation, anencephalic babies and the dying child. With all these emotive and controversial subjects we have been fortunate to have had some very talented speakers, many being experts in their particular field. It is this which has succeeded in attracting large audiences and creating an interest in medical ethics which we hope to carry forward into our third year as one of the successors of the LMG.

This year we hope to expand as a group, emphasising the importance of medical ethics for all those working in the health care field. Topics for discussion in the 1991–92 academic year include symposia on patient choice, embryo zapping, resuscitation—a life or death decision?, virgin births, drugs and research, religious surgery and asylums—back to the good old days? Further details of these symposia and other future plans for the group can be obtained either from the Coordinating Secretary, Dr G S Clayden, MD, FRCP in the Department of Paediatrics at St Thomas's or from the Chairman Mr S Dasan, c/o St Thomas's House.

E D Lehmann
Vice-Chairman (St Thomas's Campus)

AZT and acyclovir for Aids

A clinical trial involving British, German and Australian patients using a combination of AZT, a reverse transcriptase inhibitor and acyclovir, an anti-viral drug used in the treatment of herpes, showed that the death rate from Aids was halved using a combination of both drugs compared to using AZT in isolation. The three year trial was halted to allow all the patients taking part to be given the combined therapy. The treatment is based on evidence suggesting that cytomegalovirus, a herpes virus, is a co-factor in the development of Aids. If other co-factors can be identified, it is hoped that cocktails of several drugs may bring the disease under control.

This news follows the Health Department's announcement that the highest number of new Aids cases recorded in a month was in November last year.

UMDS research workshop

A half day workshop is scheduled to be held on 3 March in the Roben's Suite at Guy's. Three invited speakers, from the Association of Medical Research Charities, the Wellcome Trust and the MRC will give background information about their organisations as well as practical hints on writing reserch grants. The workshop will be followed by a buffet lunch. To reserve a place, please apply in writing to Dr Lynn Carlisle in the Research Secretariat, giving your name, department, job title and a contact phone number, together with a cheque for £5 payable to UMDS. There are only fifty available places which will be allocated on a first come, first served basis.

Galaxy

In its long history, Guy's Hospital has never had a gay and lesbian association.

Why?

Well we really don't know. Lesbian and gay medical students, doctors, nurses, physios, dentists and other health care workers have always existed, but surprisingly no society has ever been established.

Galaxy—the Gay and Lesbian Association of Guy's and St Thomas's Hospitals—has been set up to correct this. It is an association for all lesbian and gay men working and studying at either of these two hospitals, and it will operate just as any other society at Guy's and St Thomas's operates.

Just as the rugby or rowing club, for example, exist to identify those people interested in those particular sports, or to use some other examples, take the Christian or Islamic societies, which are there for people of the same religious persuasion. Galaxy has thus been formed to identify and bring together lesbians and gay men so that they meet in an informal, relaxed and non-threatening atmosphere.

So, the next time you see a Galaxy poster, don't tear it down or scrawl over it. Instead, leave it be and tell all your lesbian and gay friends about Galaxy.

If you would like more information, please write (in the strictest confidence) to: Galaxy, BM/GMA, London, WC1N 3XX.

Secretary, Galaxy

New Year's Honour

The Gazette is pleased to note that Leslie J Cheeseman, BDS, LDS, DDPH, RCS has been awarded the BEM in the 1992 New Year's Honours, for services to cricket umpiring. At Guy's from 1948–54, he has always been actively involved in cricket, changing from playing to umpiring in the 1950s. Mr Cheeseman has the distinction of being the first ever non-professional umpire to stand at Lord's, during the Haig National Village final, and still remains the General Secretary of the ACU, the representative body for cricket umpires.

Currently Mr Cheeseman is working as consultant in dental public health for the Epsom Health Care Trust, Mid Surrey and Merton & Sutton Health Authorities.

Annual dinner

South Wales Guy's Hospital Society
Saturday 21 March 1992–7.30 pm
Park Hotel, Cardiff

This year the committee has agreed that members of the society may invite guests, both ladies and gentlemen, medical, dental or otherwise. Anyone who has had their professional training at Guy's is invited and may bring a guest. Guest of honour is Dr John Davies, consultant in sports medicine.

The cost will be £18 per head, wines not included. Applications to Graham Davies, 23 Windsor Road, Radyr, Cardiff, CF4 8BQ. Tel (0222) 842479.

Congratulations

Professor Sir Cyril A Clarke, at Guy's from 1929–36 is to be awarded an honorary Doctor of Science degree by The College of William and Mary, Williamsburg, VA. Professor Clarke is working in the Department of Genetics and Microbiology at the University of Liverpool. The award has been made in recognition of his career as a distinguished biologist and educator.

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The Bore Report

High prices and high jinks at Guy's

Having been abroad for so long I was, as you can gather from my last communication, amazed to find out how much had changed in family Guy's. I am sure that even the elective students as they return from foreign vocations (or vacations) will hardly recognize the hospital in which they have spent the last five years.

Take, for example, the Spit with its new pricing system—obviously created by someone as greedy as an oversized eagle but with the business sense of a demented sparrow. Value for money in the Spit is now surpassed by only the price of the Dental Ball, how reasonable it is to pay £1 for a cup of coffee or £3.30 for sandwiches that contravene the trade descriptions act? I tried lunching in the Spit yesterday but was unable to make an appointment with my bank manager to extend my blossoming overdraft limit. Still you pay for quality—usually!

I see that the flu which caused President Bush such an embarrasing moment has not yet got around the student body, but one of the recently unattached girls in the fourth year seems to be making up for this. I think Jamie Combes will have to do more than buy her a curry if he wants to join his friends at her dinner table . . .

With the Hospitals' Cup approaching I wonder if the Freshers will be able to show the old boys a trick or two. Faces to look out for include John 'the Sturgeon' Davis who has apparently curdled his way to notority and inflicted remarkable amounts of damage to some of the more senior members of GHRFC who apparently now live in fear of meeting him in the basement of Boland House. Another Fresher to take note of is the one they call Pit Pony (owing to his rather dubious parenthood) who is planning to celebrate a cup victory with another of his general inpromptu hair washes. Roy and his merry men however seem to have everything under control now that the outbreak of foot and mouth disease has been controlled and I wish them every success in their cup campaign. (Oh, and good luck to St Thomas's as well.)

With Christmas and the New Year now safely behind us we can all look forward to another year of hectic activity in 1992 and personally I cannot wait to chronicle the ins and outs of the student body over the next year.

Cedric Bore

The Residents' Play 1991

Back with a vengeance

In the days when 72 hours made up a normal three days work and the house officers' review was the residents' play, the organisation of this event was much easier. There were many hours on call to be filled in, rehearsal was simpler, consultants' wives could lend suits without raising suspicion and the show would run for three days. Now that few junior doctors live on site, time on call is much busier and consultants have only one suit and one wife the arrangements are more difficult. After a blank year it was good to see a revival even if it only ran for one night.

It seems that most senior staff winding down slowly towards Christmas were caught napping by the sudden appearance of the review. Only around six consultants were quick enough to catch the brief appearance on the last Friday before Christmas. It was a shame so few managed to come, I am sure 'Dr Rosenkrantz' would have enjoyed the attentions of Helen Pritchard as much as Ron Simon evidently did on stage.

Such reviews usually have a loose attachment to some theme and in this case it was the Wizard of Oz transposed to Guy's with the Old Kent Road as a substitute for the Yellow Brick Road. It was a very loose connection. My learned friend Dr Wilkinson, whose colonoscope managed to traverse the whole length of the gastrointestinal tract in a previous play and who evidently knows the literature well, informed me that the sister of the West should not be wicked at all. I suspect this may just have been his ploy to appease Sister Thomas so that he would be allowed to do more than half an ERCP each week.

Andy Williams managed the remarkable feat of writing much of the script, playing two different consultants and a game show presenter and curing his alopecia. His work rate was only approached by Shubulade Smith. She was on stage for most of the evening and survived that delight of house officers, being shadowed by a medical student. The student was played by Aman Coonar and, like all good students, was in awe of everyone he met despite constant mistreatment and humiliation.

The token student and sister have appeared before but the increasing importance of postgraduate education was acknowledged by the inclusion of a glamorous postgraduate secretary. The militant side of junior staff was shown in a 'restrained' performance by Jon Hare as a clinical pharmacology lecturer, Dr Cockrot. If he had sported a beard I think I might have been able to guess who he was.

The plot seemed to concern the need for a CT scan on a friend of a lordly little old man who showed great concern for the welfare of his house surgeon. It lost touch with the real world since the CT scanner was not broken but the barriers put up by Dr Catkin meant that it might just well have been. It seemed to be nearly as difficult to get a CT scan as an endoscopy.

Fortunately some prominent members of the Trust were able to put in an appearance, these included Dr Pott complete with cycle helmet, peace and an attitude laid back near to the horizontal, an unnamed administrator and even Sir Dillip Parris himself. The topical script was even able to comment on the Can Can from the recent Trust Christmas Party, the artistic content of which had received such widespread acclaim just two days earlier.

Two members of the audience, John Spencer and Peter Taylor, were brave enough to venture on stage for a song rejoicing in the lethality of Bob Mason's laser. Mr Spencer was rewarded with a barrage of comments about his lack of inches and Mr Taylor with a portrayal, as Wodehouse put it, 'as if he had been poured into his clothes and forgot to say when'.

The play showed its usual startling knowledge of recent medical advances by changing the usual sigmoidoscopy or colonoscopy song to a celebration of laparoscopic surgery, embelished by a dance over crossed laparoscopes by Andy Williams.

There were lots of enjoyable moments in the evening. The single night's run is presumably connected to the reduction of junior doctors' hours to a couple of half days a week. If it could have run for another one or two nights it would have become even better allowing more confidence and cohesion in the songs. There were splendid performances from Andy Williams, Shubulade Smith, Mel Evens, Luke Membrey, Emma Ross and Aman Coonar amongst others and it was good to see the tradition of the residents' play reinstated. The cast list even awarded Thomas Guy his long overdue knighthood.

John Rees

Paediatrics—1968

The further adventures of Dr Pitt-Payne

By the time we came to paediatrics we had all done the elective period. I spent my elective peering down microscopes at red cells, white cells, platelets and the like. Two months of that convinced me that haematology was not for me. My elder brother, Michael, had already fathered three sons thanks to the good offices of his wife, Anne, and I was already into the rudiments of avuncularity and wallowing in those all too brief moments of playing the role of 'Uncle James'. One of the first things I had to come to terms with was the fact that children and babes-in-arms were always smaller than grown-ups—invariably so. But they were larger than red cells, so things were looking up. Many memorable names spring to mind in this connection. The big two, though, were Dr Philip Evans and Dr Ronald MacKeith. For those to whom these are merely names it would be hard to describe the universal affection in which they were held by anyone who came anywhere near them. Sadly, they are both gone now but their memory is as fresh in my mind as though it were yesterday. Dr Evans was a kind, quietly-spoken man who imparted wisdom on every ward round and I would give my eye teeth to hear him again. I was too young to be paying proper attention on his rounds and my eye teeth were taken some years ago now. Though I was on the 'Evans' firm, the frequent sayings of Ronnie MacKeith filtered through and there were treats in store every time he spoke. He spoke as one whose soft palate was non-operational so that everything he did say came from him with an emphasis which made it memorable. He was a natural target for Residents' Plays and Dave Briggs 'did' him terribly well in the 1971 offering by the 'House'. The song that was sung on that occasion in February 1971 has words which will ring bells everywhere, I'm sure:

Up in the children's ward,
Look out! He might go 'Boo',
Is a suede-shoed, glass-eyed monster
And I think that you know who
He is, and what he is,
It needs no explanation,
And his world revolves around a red carnation.

He wears an old blue suit
And a dirty tie to match,
But when it comes to treating kids
Not many are a patch

On him, it's not a whim,
But his very motivation
And his world revolves around a red carnation.

The heights of little girls he finds
Is one of nature's joys,
But even this cannot compare
With the lengths of little boys.
Oh what a bore, he's looking for
New ways of mensuration
And his world revolves around a red carnation.

He finds delight in female form,
A breast as soft as silk,
And recommends the lukewarm taste
Of human mothers' milk.
It's clean and sweet, goes down a treat
And needs no mastication,
And his world revolves around a red carnation.

That Resident's Play was masterminded by Michael Simpson—and if it was he who wrote those words he'd be at least a Professor of Psychiatry by now, I'll be bound! (See *Guy's Gazette* No 2157–27 March 1971)

There were theories galore as to why he wore a red carnation but I need not entertain them here, and there was an outpatients when he did wear a tie but had forgotten to make a knot. No one thought to say anything about it because it seemed right at the time. He was that kind of doctor. In matters of breast feeding he held some quite eccentric views; one suggesting that nurses bottle-feed babies stripped to the waist. It may have had the mark of hilarity about it—if he really did say that—but beneath the comments were new ways of trying to make us look at paediatrics, and it was in this sphere that he was so successful with us.

Our senior registrar was Sam Meadow, now Professor at St James's University, Leeds. It can't have been easy for him when faced with us lot. I don't think we were always very receptive. We were well over halfway through the clinical course and our brains were starting to reel with the weight of information they'd already been crammed with. It was at about this time that the multiple choice question examination made its entrance into the curriculum and it proved a useful way of seeing if anything had stuck there—in the grey matter. The textbook in vogue for us was Hugh Jolly's *Diseases of Children*, second edition, and I still have mine handy in case I get stuck with parents who want to know more than I can spill in the way of beans at the time they're needed.

Developmental assessment was relatively new and very much part of the scene and periodically we would go and see how it was done. One of the most

important things was to find out the infant's name and I remember the day we all cracked up at the mother who called her child 'Melaena'! I expect it happens from time to time but when you're there it's the funniest thing since time began.

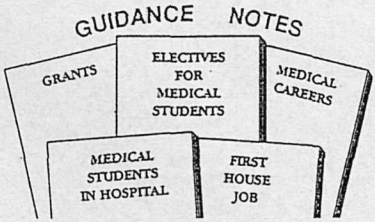
We also felt we had reached new heights of silliness when at Christmas on Caleb and Diplock in Hunt's House we misused the cylinder of helium supplied for the balloons and filled rubber gloves to bursting with the stuff before tying the knot. These somewhat obscene alternative Christmas ornaments hung at ceiling level and caused a certain amount of innocent merriment.

Then there was Marcus Pembrey's dragon which he had constructed at the Evelina Hospital whilst working there. It was a very fine dragon, some twelve feet long and made of wood, chicken wire, and papier-mâché. On the twelfth day of Christmas we had been invited to Leo Stimmler's home one evening whilst on take-in. Marcus had a very fine Bentley motor car, circa nineteen-thirty-something and we all piled into it for the journey from Guy's down to Shortlands, Bromley, Kent where Dr Stimmler entertained us most generously. Needless to say, the journey back was rather noisier than the journey there and at one in the morning nobody really felt ready for bed. Also, there was—we realised—a dragon to be disposed of. We went down to the Evelina and hefted this monstrous thing through Borough High Street with every intention of crossing the rapidly disappearing old London Bridge and leaving it next to the Monument. When we got there, some gentlemen from the press took photographs of us and then the police came—as if from nowhere—which is, as we all know, where they usually come from, and asked us very politely if we would remove the thing. By now, it was getting on for three in the morning and it was decided—unanimously—that the patch of grass beneath the Dean's window would be a very jolly place to put it—looking up at his window as it were. I got up the following morning—or the same morning as it happened—and was able to see the form of Dr Houston looking down at this dragon from my vantage point in Hunt's House. I feel proud to have been one of the puerile party who indulged in this harmless jape and I don't think anything further was ever said about it. If Dr Houston can remember the occasion, this is the story behind it. I also saw it being cruelly dismantled by an operative who had been detailed to dispatch the thing.

We had a two week spell at Queen Mary's, Carshalton, a massive place doing a fine job of work. As students, we were mere onlookers and there was much to see there; things that made us wonder. When I look back I saw more there that personally challenged me than I cared to acknowledge at the time. I had had a somewhat sickly, snotty childhood—hard to believe when you see me now—and it was just that kind of background that made paediatrics so much more of a challenge and still the fascinating subject I find it today.

J H Pitt-Payne

BMA



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London Marathon '92

Why, oh why do they do it?

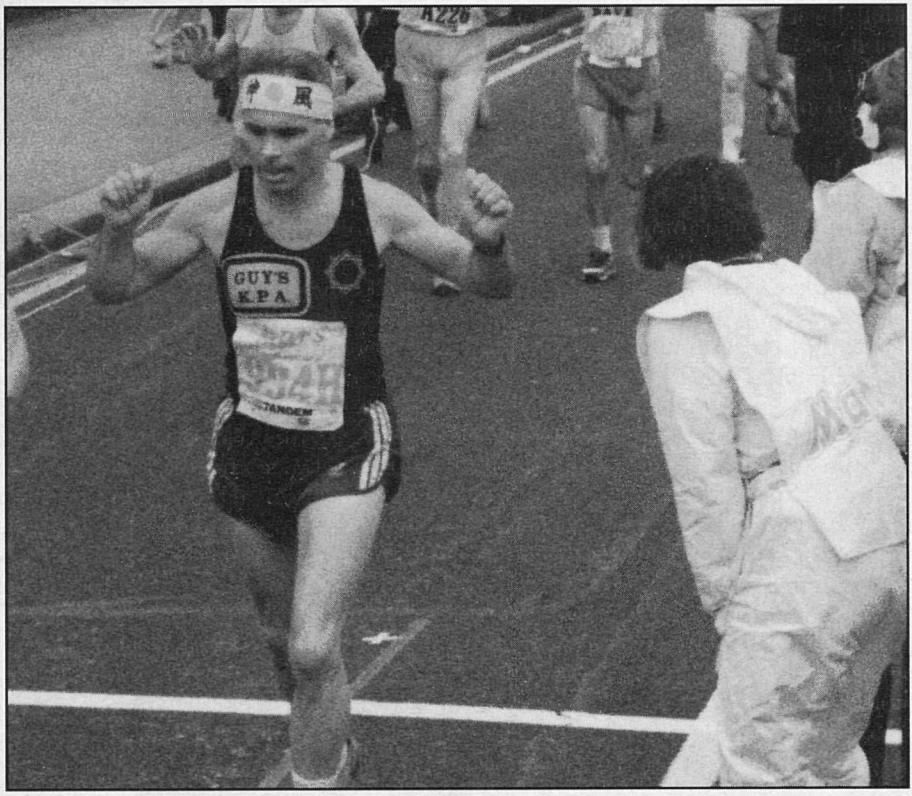
It is difficult to see the attraction of the marathon to a middle aged, overweight man with knee joints ravaged by playing rugby for at least five years longer than is decent. Could it be that a degree of brain damage has already occurred which seriously impedes the sensation of pain? Surely the prospect of pounding out mile upon mile during the dark winter evenings would deter any sensible human being. It has already been scientifically shown that jogging is the most boring activity known to man. Further more it can significantly damage your health and shorten your life.

The social side of the sport involves learning of a whole new communication system of grunts, snorts and expletives as well as an encyclopaedic knowledge of the inside of the knee and ankle joints. A detailed knowledge of designer tracksuits, running shorts with inbuilt scrotal support, running vest with optional surgical corset and finally of course the bewildering choice of at least 100 different types of running shoe, are all vital components of the overall marathon effort. If you cannot do the running, look stunning.

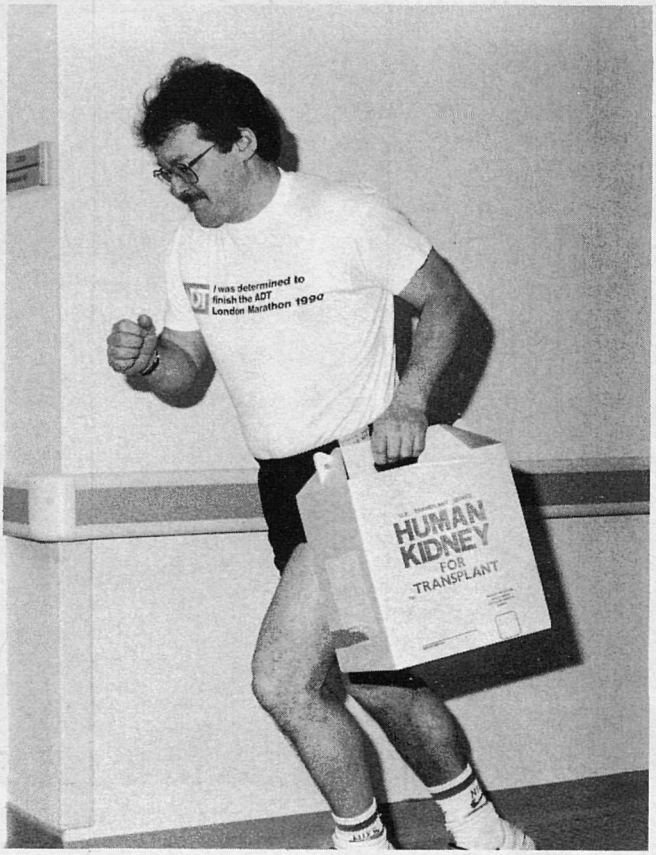
With the decline, almost to extinction, of the North American buffalo and the famous stampede, the only spectacle which can remotely compare with this is the modern marathon! FOR THE SPECTATOR. For the participant who is generally of similar intellectual capability as the North American bison it is indeed a fight for survival. The goal is simply to finish, to survive and to start planning how to avoid next year's marathon. The other main problem is how to prevent your friends from discovering your finishing time and to avoid the invidious comparison with aunt Ethel, aged 59, who beat her personal best by 30 minutes whilst wearing fancy dress as well as juggling continuously for 26 miles!

Is it that I will learn more about myself during this prolonged process and at the end be a better person? Do I expect that it will provide me with time to contemplate and to throw the rest of my life into the proper prospective? Or will I lose weight and become fit and healthy again? Do I seek glory and public acclaim or merely a sort of rejuvenation? All these questions will be slipping in and out of my consciousness during the next few months as I prepare for the forthcoming event. I have committed myself to raise at least £1,000 for Guys Kidney Patients Association, but we all know that this cannot be the real motivation.

Geoff Koffman
Consultant Transplant Surgeon



Prof Cameron—several marathons under his belt



Mr Koffman—recently spotted training!

Tam O'Shanter

Preventative medicine from the Scots

Robert Burns' famous poem, Tam O'Shanter, warns us of the dangers of alcohol, about which we now have much more information. For instance, an 11 stone man is putting his liver in danger if he drinks more than the equivalent of twenty small whiskies in a week, and a woman of the same weight is limited to fourteen similar measures in a week. A lesser volume may impair the future well-being of our brains.

Although Robert Burns is revered throughout the world, he is less appreciated south of the border, largely because English speaking people are unfamiliar with many of the Scottish words such as *fou, unco, skellum, bellum, amang the nappy, fidg'd fu'faing* and *eldritch skreech*. Even words that the English think they understand have quite different meanings. For instance, *pussie* means a hare.

I have translated the obscure words where it does not disturb the rhythm, rhyme or assonance. Elsewhere I have added the translation in brackets of the words italicised in the text. The trouble with partial translations is that they may end up with something which is neither fish nor fowl. In order that our southern listeners can enjoy Tam O'Shanter with its important lessons in preventative medicine, the following is offered as a *cockshy*.

Ian McColl

When doorstep pedlars leave the street,
And thirsty neighbours neighbours meet,
As market-days are wearing late,
An' folk begin to take the *gate;* (road)
While we sit boozing at the *nappy,* (ale)
An' getting drunk and very happy,
We think not on the long Scots miles,
The mosses, waters, *slaps* and stiles, (gaps in walls)
That lie between us and our hame
Where sits our sulky sullen dame,
Gathering her brows like gathering storm,
Nursing her wrath to keep it warm.

This truth found honest Tam O'Shanter,
As he from Ayr one night did canter,
Old Ayr which never a town surpasses,
For honest men and bonny lasses.

O Tam! had'st thou but been so wise,
As taken thy own wife Kate's advice!
She told you well you were a *skellum* (rogue)
A blethering, blustering, drunken *blellum* (babbler)
That from November till October,
A market day you were not sober;
Each load of grain you took the miller
You sat as long as you had *siller;* (money)
That every horse which had a shoe on,
The smith and you got roaring *fou on* (drunk on)
That at the Lord's house, even on Sunday,
You drank in Kirkton Pub till Monday.
She prophesied that, late or soon,
You would be found deep drowned in the *Doon* (the river Doon)
Or caught with warlocks in the *mirk,* (dark)
By Alloway's old haunted kirk.

Ah gentle dames! It makes me weep,
To think how many counsels sweet,
How many lengthened sage advices,
The husband from the wife despises!

But to our tale: One market-night,
Tam had got firmly planted right,
Nearby a fireside, blazing finely,
With frothing ale that drank divinely;
And at his elbow cobbler Johnny,
His ancient trusted, thirsty, crony;
Tam loved him like a very brother;
They had been drunk for weeks together.
That night drove on with songs and clatter;
And still the ale was growing better:
The landlady and Tam grew gracious,
With favours, secret, sweet and precious:
The cobbler told his queerest stories;
The landlord's laugh was ready chorus:
The storm without might roar and rustle,
Tam did not mind the storm a whistle.

Care, mad to see a man so happy
E'en drowned himself among the *nappy;* (ale)
As bees fly home with load of treasure,

The minutes winged their way with pleasure;
Kings may be blessed but Tam was glorious,
O'er all the ills of life victorious!

But pleasures are like poppies spread,
You seize the flower, its bloom is shed;
Or like the snow falls in the river,
A moment white—then melts for ever;
Or like the borealis race,
That flit 'ere you can point their place;
Or like the rainbow's lovely form
Evanishing amid the storm.
No man can tether time nor tide;
The hour approaches Tam must ride;
That hour o'night's black arch the keystone
That dreary hour he mounts his beast in;
And such a night he takes the road in,
As ne'er poor sinner was abroad in.

The wind blew as 'twould blow its last;
The rattling showers rose on the blast:
The speedy gleams the darkness swallowed;
Loud, deep, and long the thunder bellowed;
That night, a child might understand,
The *deil* had business on his hand. (devil)

Well mounted on his grey mare, Meg,
A better never lifted leg,
Tam rushed on through *dub* and mire, (puddle)
Despising wind, and rain, and fire;
While holding fast his good blue bonnet;
While crooning o'er some old Scots sonnet;
While scowling round with prudent cares,
Lest bogles catch him unawares;
Kirk-Alloway was drawing nigh,
Where ghosts and owls do nightly cry.

By this time he'd crossed the ford,
Where in the snow the pedlar died,
And passed the wood and mighty stone,
Where drunken Charlie broke neck bone,
And through the rocks and by the cairn,
Where hunters found the murdered bairn;

And near the thorn above the well,
Where Mungo's mother hanged hersel'.
Before him *Doon* pours all his floods; (river Doon)
The doubling storm roars through the woods;
The lightnings flash from pole to pole:
Near and more near the thunders roll:
When, glimmering through the groaning trees,
Kirk-Alloway seemed in a *bleeze;* (blaze)
Through every cranny beams were glancing;
And loud resounded mirth and dancing.

Inspiring, bold John Barleycorn!
What dangers thou canst mak' us scorn!
With the ale we fear no evil,
With the whisky we'll face the devil!
The drink so frothed in Tammie's noddle,
He did not care for deils a *boddle.* (farthing)
But *Maggie* stood right sore astonished. (his mare, Meg)
Till, by the heel and hand admonished.
She ventured forward on the light;
And wow! Tam saw an aweful sight!
Warlocks and witches in a dance;
No cotillion brand new from France,
But hornpipes, jigs, strathspeys, and reels,
Put life and mettle in their heels.
At window seat sat in the east.
Old Nick, the Deil, in shape of beast;
A shaggy dog, black, grim and large,
To give them music was his charge;
He screwed the pipes and made them skirl.
Till roof and rafters all did *dirl* (shake)
Coffins stood round, like open presses.
That showed the dead in their last dresses;
And by some devilish magic slight.
Each in its cold hand held a light.
by which heroic Tam was able
To note upon the holy table,
A murderer's bones in gibbet *airns;* (irons)
Two span-long, wee unchristened bairns;
A thief just cut down from a *rape,* (rope)
With his last gasp his mouth did gape;

Five tomahawks, with blood red-rusted;
Five scimitars with murder crusted;
A garter, which a babe had strangled;
A knife, a father's throat had mangled.
Whom his own son of life bereft,
The grey hairs yet stuck to the *heft;* (handle)
With more of horrible and awful,
Which even to name would be unlawful.

As Tammie stared amazed and curious.
The mirth and fun grew fast and furious;
The pipe loud and louder blew;
The dancers quick and quicker flew;
They reeled, they set, they crossed, they *cleekit,* (linked arms)
Till each old hag did sweat and *reekit* (steam)
Stripped off her clothes to help the work,
And tripped at it in her short shirt.

Now Tam, O Tam! had these been *queans* (young women)
All plump and strapping, in their teens:
Their shirts instead of greasy flannel,
Been snow-white much the finer linen;
These breeks of mine, my only pair,
That once were plush, of good blue hair.
I would have given them off my *hurdies* (hips)
For one blink of the bonnie birdies!
But withered women old and droll,
Villainous hags would wean a foal,
Leaping and flinging on a *crummock* (crutch)
I wonder did not turn your stomach.

But Tam knew what was what *fu'brawlie:* (full well)
'There was one winsome wench and *wawlie'* (spirited)
That night enlisted in the core,
Long after known on Carrick shore!
For many a beast to death she shot,
And perished many a bonnie boat,
And shook both much of corn and *bear* (barley)
And kept the country-side in fear.
Her *cutty sark, of Paisley harn,* (short skirt of coarse linen reminiscent of a mini skirt)

That while a lassie she had worn,
In longitude though sorely scanty,
It was her best, and she was *vauntie.* (proud)
Ah! little knew their reverend grannie,
That sark she bought for her wee Nannie,
With two pounds Scots' 'twas all her riches,
Would ever graced a dance of witches!

But here my muse her wing must cower;
Such flights are far beyond her power:
To sing how Nannie lept and *flang,* (kicked)
A supple lass she was and strang,
And how Tam stood, like one bewitched,
And thought his very eye enriched;
Even Satan glowred, and *fidg'd fu'fain,* (wriggled with pleasure)
And hotched and blew with might and main;
And first one caper, then another,
Tam loses reason altogether,
And roars out, 'Well done, *Cutty-sark!*' (short skirt)
And in an instant all was dark;
And scarcely had he Maggie rallied,
When out the hellish legion sallied.

As bees buzz out with angry moan,
When plundering herds assail their home,
As open *pussie's* mortal foes (hare)
When pop! She starts before their nose;
As eager runs the market-crowd,
When 'Catch the thief!' resounds aloud;
So Maggie runs, the witches follow,
With many a hellish screech and hollow.

Ah, Tam! Ah, Tam! thou'll get thy *fairin* (deserts)!
In hell they'll roast thee like a herrin'!
In vain thy Kate awaits thy comin'!
Kate soon will be a woeful woman!
Now, do they speedy utmost Meg,
And win the key-stones of the bridge;
There at them thou thy tail may toss,
A running stream they dare not cross.
But 'ere the key-stones she could make,
No tail at all she had to shake!

For Nannie, far before the rest.
Hard upon noble *Maggie* pressed. (His horse Meg)
And flew at Tam with furious *ettle;* (purpose)
But little wist she Maggie's mettle—
One spring brought off her master's *hale* (whole)
But left behind her own grey tail:
The old hag caught her by the rump,
And left poor Maggie scarce a stump!

Now, who this tale of truth shall read,
Each man and mother's son take heed:
Whene'er to drink you are inclined,
Or Cutty sarks run in your mind,
Think, you may buy the joys o'er dear,
Remember Tam O'Shanter's mare.

Robert Burns

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Articles for inclusion in the *Gazette* should be supplied double spaced, and preferably typed. If handwritten, names in particular should be clearly legible. If contributions are prepared on a word processor it would be particularly helpful if a floppy disk containing the article is supplied along with a printed copy. Where possible, text should be saved in ASCII format—or if in any doubt, full details about compatibility of different files can be obtained from the *Gazette* office.

All feature articles should be received by the first Friday of each month prior to publication. Features should be approximately 500 to 1500 words. At present, late news and sports results can usually be accepted upto one week later. It is hoped that it will be possible to extend this deadline in the coming months. Authors are requested to supply a contact phone number, in case of any queries that arise.

So, now you know what to do to get your name in print—get writing! Final year students in particular are requested to send material about their electives—even if it only consists of anecdotes.

407 Art Club

When the 407 Art Club started at Guy's over a decade ago, few expected that it would survive more than a few years. I am happy to report that, at least fifty shows later, the Club is still active and well attended by its appreciative public. The last exhibition, starting 9 December, was very successful. The best evidence is that 14 members of the Guy's campus staff, or their close relatives, presented their work—an anthology of various styles and techniques, including drawings (Despina Savva, Natasha Crowcroft, Susannah Nasskau, Mark de Pienne), watercolours (Maurice Lessof, Terry Gibson, Roy Spector), oil paintings (Jenny Cameron), pottery (Jane Gibson), and mixed media (Meg Dinkeldein, Anita Price, Sidney Leibowitz, Matteo Adinolfi).

Surely this is a testament to the power that art has on our creative impulses, whether or not the technical skill, and the time to acquire it, allow for perfection.

If there is a statement that can legitimately be made about the artistic qualities of the work presented, it is that each piece is a commitment to self-expression.

Many who visited the 407 Art Club show have enquired about the next exhibition—this is scheduled for this spring.

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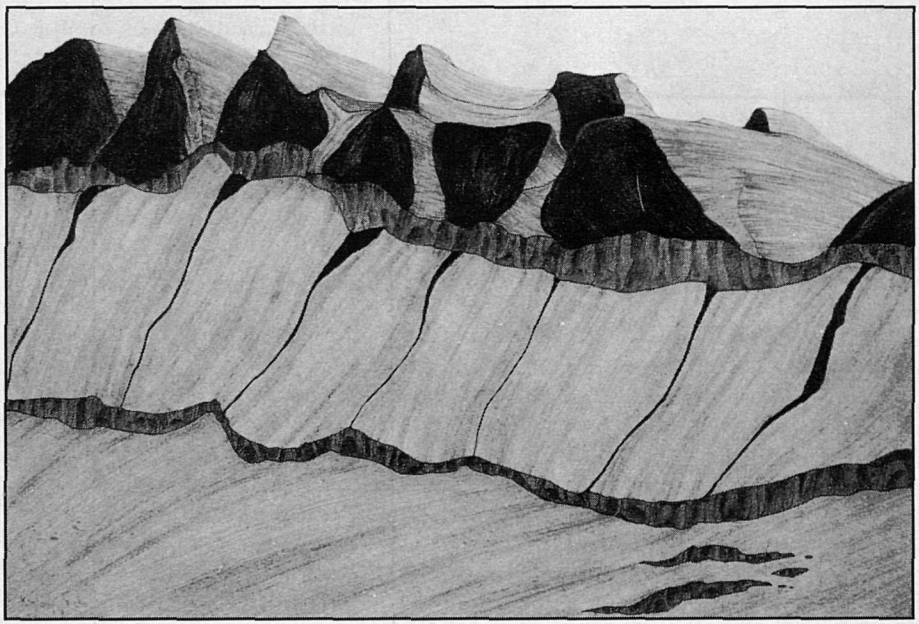
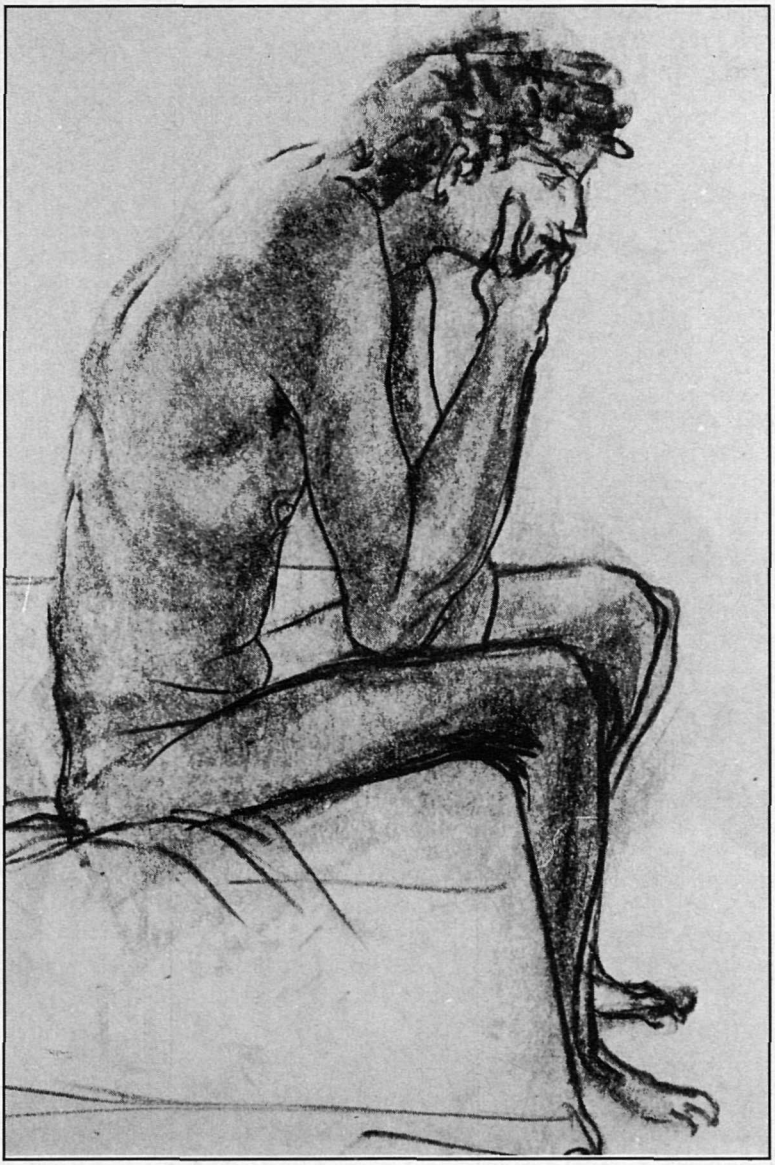


'India View' by Mark de Pienne



'Sitting figure' by Despina Savva

Understand Biostatistics Thomas H Hassard (1991) Published by Mosby Year Book Price £20

This three hundred page soft covered book sets out to 'demystify this fascinating and very relevant subject' to health scientists, and those wishing to keep up to date with scientific literature. The author (a professor of Biostatistics in Canada) claims in his preface that a mathematical background is unnecessary for use of his book and that the ideas underlying biostatistics are almost embarrassingly simple. I disagree with this latter claim, as would many medical and dental students, together with a host of postgraduate researchers. Indeed the author disproves his own claim by a thorough and meticulous build up to every concept he tackles in his book. The very strength of the book is the patient explanation of the need for each statistical technique that he introduces. There are no pithy summaries, and researchers looking for a rapid 'cookbook' approach will be disappointed.

It has become extremely fashionable for teachers of statistics to claim that they are interested in teaching concepts rather than the mechanical details. Unfortunately such concepts rarely mean anything until practical examples are found to illustrate them. Wading through fully worked examples can lead to an apparent over-emphasis on details, which is far from 'embarrassingly simple' and can be rather tedious unless you are working with your own data.

Actually the author spends the first seven chapters on data handling, and relatively simple techniques. The style is pleasantly chatty and avoids formal statistical jargon until as late as possible in each chapter. There are plenty of relevant examples, some of which seem to be artificial (i.e. do not derive from real data). At the end of most chapters, exercises are provided (no MCQs), with solutions in one of the appendices.

Why should you bother with this subject at all unless you are likely to be involved with postgraduate research? Well, much of the practice of medicine derives from research which frequently depends on statistical ideas and techniques. To understand the current advances, as seen in the pages of the *BMJ*, *Lancet*, etc, requires some understanding of statistics, in particular the ability to be critical. Hence I was disappointed that the book did not discuss much on critical appraisal of the medical literature. On the whole, the emphasis of the whole book was on data analysis rather than study design, yet the former is arguably meaningless without the framework of the latter.

Despite this, the book was actually very well written and may well be palatable but pricey to those trying to master the subject for the first time. It will be less helpful for the would-be researcher.

Richard Morris
Lecturer in Medical Statistics

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Dr John Henry Lewis

John Henry Lewis, born on September 25, 1919 in Penarth, Glamorgan, Wales, passed away peacefully on August 2, 1991 after a long battle with an anaplastic cancer which he fought with immense courage, fortitude, and determination. He is survived by his wife, Adele, their son Adam, and another son, Dr Mark Lewis of Oxford, issue of a previous marriage contracted in 1948 in England.

John Henry's father died when he was three years old. He studied at Lindisfarne, a school of rigorous discipline, setting high standards of excellence, which undoubtedly influenced him in his search for excellence in all things, which was an integral part of his character.

He graduated from Guy's in 1943, and served in the RAMC from 1948 to 1950, and then spent some time in general practice, with some early training in dermatology at the Radcliffe Infirmary in Oxford. Then in 1955, attracted by stories of Western Canada and the writings of Rudyard Kipling, he left his home in Hereford for Victoria, Canada, where he became an intern at the then—St Joseph's Hospital, later the Victoria General Hospital, where later he became Chief of Medical Staff from 1976 to 1978. Further training in dermatology was obtained at the University of Chicago under the eminent American dermatologist, Dr Rothman.

Rothman was a somewhat abrasive character, but John Henry was not discouraged, and completed his training with due honour, later being awarded a fellowship of the Royal College of Physicians of Canada. Happily, he also joined with me in dermatological practice in Victoria. John Henry's efforts resulted in the opening of the immensely successful Psoriasis Clinic, which he continued to direct until forced by ill-health to retire.

It says a great deal of his character that in all our 30-odd years of friendship and partnership, never a cross word passed between us. We had differences of opinion, of course, from time to time, but these were always resolved with the help of his intelligence and good humour.

John Henry met Adele three weeks after his arrival in Canada, and they were married in 1962. It was the happiest of unions, his intelligence and innate kindness matched by her vitality and artistry.

John Henry was a man of many talents and interests. He loved his work and was excellent with patients and people of all ages. He loved to talk, and always had time to listen with an intelligent and sympathetic ear. He spent much time talking to his psoriasis patients, both individually and collectively. He was a most entertaining and amusing public speaker, being a founder member of the VMS Speakers Group.

He was a member of many professional associations, including the Victoria Medical Society, the BC Dermatological Society, The Pacific North-West Dermatological Society, of which he was President in 1983, the Pacific Coast Dermatological Society, the American Academy of Dermatology, and the CMA.

We mourn his untimely passing, but we are grateful for the years of dedicated service he was able to give us. Apart from his dedicated professionalism, he must chiefly be remembered for his intelligence and his sense of humour, and his sense of 'timing' in public speaking.

Kemble Greenwood, FRCP
Victoria, Canada

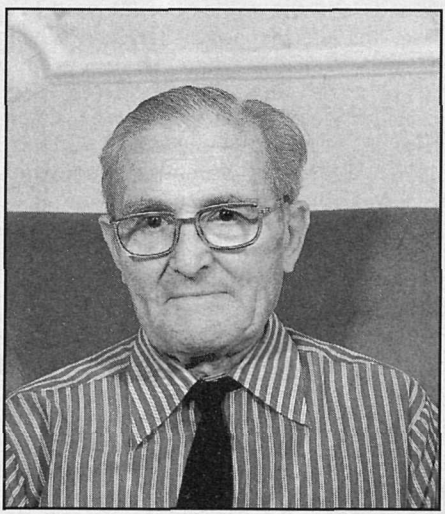
Christopher Sydney Darke, MD, FRCP

Chris Darke (always Chris never Christopher) was one of the outstanding Guy's men of the 1930s and was the first preclinical tutor when the medical school moved from Guy's to Pembury at the outbreak of war in 1939. Those who were at Guy's at that time will be saddened to learn of his death this year at the age of 78.

His father Sydney J Darke, MC, also a Guy's man, was a GP in Hounslow. His mother had been trained in physical education and was a natural games player. He was the only member of his family to go into medicine, but his sister Mary became a medical social worker. From his father Chris inherited his brains and from his mother his quite exceptional talents as a sportsman. Chris came to Guy's in 1931 from Mill Hill where he had been Senior Monitor (head of school) and captain of both rugger and hockey as well as being a runner and a swimmer. He had also played rugby for Middlesex. At Guy's he had a great sporting career. He became captain of the rugby team and is remembered as a dashing, fast ranging wing forward. Most men give up rugger when they qualify. House jobs are too demanding. But Chris organised his life so well that he was able to go on playing until the war put a stop to it.

But he was not only a games player. He was also brilliant academically. He was a student demonstrator in anatomy, pathology and bacteriology. He took his conjoint in 1935 and his MB a year later. Only two years after his MB he obtained his MRCP at the first attempt and he was awarded the University Gold Medal for his MD in 1939. He was HP to Sir Arthur Hurst and Sir John Conybeare, HS to Joey Hughes and OPO and RO before becoming medical registrar and then preclinical tutor. In 1943 he joined the army and served in Kenya with the rank of Lt Colonel commanding the military chest hospital at Nyeri. On demobilisation in 1946 he became medical registrar at the Brompton Hospital working principally with Sir Geoffrey Marshall, also a physician at Guy's where he had established the chest clinic after the first world war.

In 1950 Chris was appointed physician to the Northern General Hospital in Sheffield where he developed a first class chest unit. His early years were concerned with the revolution in tuberculosis that followed the advent of antibiotics. He took part also in an MRC trial concerned with the chemotherapy of pneumonia. He did much to develop the asthma service. Throughout his career he published articles, usually in collaboration with his colleagues, on chronic bronchitis and emphysema and on some of the more abstruse aspects of pulmonary disease.



Towards the end of his career in Sheffield he developed a special interest in occupational illness affecting the lungs. He studied the respiratory problems caused by grain dust in Lincolnshire farmers during harvesting and the reactions of hair dressers to the inhalation of hair laquer. Near the end of his time in Sheffield he was concerned in the delineation of a new multisystem disease affecting workers with Polyvinyl chloride (PVC) and visited America to study the problem further. He was a distinguished member of the British Thoracic Society. He became FRCP in 1962. He was a fine teacher and examined for the College from 1968–75.

In 1976 he left Sheffield and returned to Kent. He was appointed Executive Medical Adviser to Private Patients Plan (PPP) whose head office was in Tunbridge Wells. Chris was the first person to hold the post full time. He had to carve out a role for himself and he did so very successfully. He was concerned with the medical problems of the elderly and would have liked to establish a private assessment and rehabilitation service for them. It was a disappointment when PPP turned his scheme down.

In 1940 he married Margaret Wild, a secretary in the radiotherapy department at Guy's. Their first meeting sprung from the fact that she could not read his handwriting. Their early married life was spent in Kent and they were happy to return there when he went to PPP. They lived in a village near Hawkhurst with the delightful name of Four Throws. They had two sons, a daughter Elizabeth who became a Guy's nurse, and 8 grandchildren. In retirement Chris worked in his garden and was a keen fisherman. When he was no longer able to play hockey and had hip replacements he began to play golf, a remarkable achievement for a man in his sixties. In middle life also he and Margaret took up art and Chris proved to have a special talent with pastels.

Chris had a lifelong interest in his old school, Mill Hill. In his early thirties he was elected a governor and remained on the Board for more than 30 years. In 1981 he was President of the Old Millhillians Club.

Margaret died in 1987 and the rest of Chris' life was overshadowed by his loss. His health began to fail and he moved to Woking to be near his family. He died in a nursing home near Guildford on April 24, 1991.

A short, stocky figure, broad of shoulder, quietly spoken, basically serious but usually smiling, dapper, always modest and courteous—one of his friends described him as the sort of man who never had an enemy. But he could be tough when the situation called for it and his success on the rugger field demonstrated his courage. He was at all times a credit to Guy's and grateful for what Guy's had given him. Those who were preclinical students at Pembury in the early years of the war remember their first clinical teacher with respect and affection.

R E Irvine

Allan R F Thompson

Allan Thompson (Tommy) died on November 26, 1991. He had one of the most outstanding careers of any Guy's dentist and it spanned a remarkable period of development. He entered Guy's as a student in 1926, the same year that Montagu Hopson retired from the staff. (Hopson had been the first student to enroll in the dental school in 1889). Allan became a Consultant in 1949 and eventually retired from Guy's

in 1973. Continuing to practice vigorously until December 30, 1986. He played a major role in the transition of dentistry from relatively simple procedures to modern high-tech operating.

He was a brilliantly successful student with outstanding hand-eye coordination, winning the operative prize, the fourth year prize and the Newland Pedley Medal and Prize. Later he was awarded the travelling scholarship to study at the North Western University in Chicago. He was one of the first people to take and pass the BDS degree.

As a student he admired Dowsett and Parfitt whom he regarded as excellent surgeons, and also Malleson (who was the father of the late Monty Malleson). In later years he also praised F J Pearce, who had been to the USA and who struggled to carry out endodontics and make beautiful crowns despite the then current general belief in focal sepsis and the belief that all infected teeth should be removed. After qualifying Allan was House Surgeon to William Kelsey Fry (later Sir William) who was an excellent prosthetist. Denture work up to that time had been concentrated on the accuracy of impressions, and the setting up of artificial teeth exactly on the ridge. Wilfred Fish had then just introduced the concept of the 'third surface' and Kelsey was the first person at Guy's to appreciate the importance for denture stability of the positioning of teeth in the neutral zone of pressure.

In Chicago he was taught by Schlosser, the prosthetist, and by Loren Sayre the crown and bridge specialist, both the foremost dentists in the USA in their fields. When he returned to Guy's he started tooth carving classes for students, first of all using blocks of soap. Back in the prosthetics department he worked with Professor Fenn on the development of a Guy's articulator, and with Professor Herbert he continued work to determine the factors affecting the accuracy of inlay castings.

In 1932 Allan went into part-time practice as an assistant with the famous American dentist William Griswold in Park Lane. Griswold treated the Kaiser and the Prince of Wales but died suddenly in 1935 and by then Allan was also studying medicine, working his way through the course so he could not take over Griswold's practice. He decided to finish his medical training, and by working at the Dental School and doing part-time evening practice (with Kelsey Fry) he eventually passed his conjoint medical finals in 1939.

With F S Warner he started the periodontal department in 1936, and by the time war broke out he was almost totally involved in the Dental School, teaching in many departments and also running the dental radiology department, coming into close contact with the famous Jimmy Worth who later went out to Toronto.

After the war, practice in London gradually returned to normal, and Allan became one of a group of pioneers of modern dentistry.

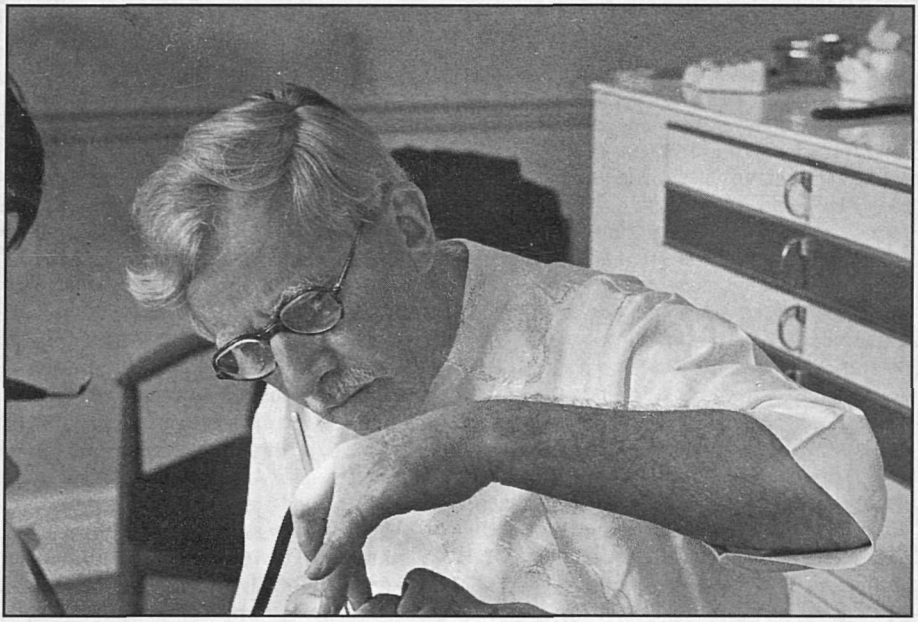
He was however probably the most outstanding all-round practical dentist of his time, with an influence on countless dentists both at Guy's and outside the hospital. His ability was so remarkable because it was so wide. To list but a few of his achievements in approximate chronological order is quite a task. First of all, in the surgical field he was an outstanding operator—perhaps one of the fastest oral surgeons one has ever seen. He had immense experience of all types of extractions from the old blood and vulcanite era, and would elevate and remove teeth that most people would deem impossible without cutting flaps and commencing a full minor oral surgery sequence. However, if a

surgical intervention were required he was the master of the techniques. Using a headlight and his sucker-cum-retractor he would remove third molars or canines in the palate and especially carry out root resections, with lightning speed. His sessions with Dr W S McConnell were started in the early days of short acting intravenous anaesthesia. They worked closely together to pioneer a safe operating technique with the patient in a head down position. He built his own automatically controlled water spray system using commercial solenoids before these were available on dental units. He was always an advocate of crown and bridge dentistry, and of course in his hands it was carried out to the highest standards. He largely introduced the cantilever spring bridge into British practice in order to replace missing anterior teeth. This technique used pinlays on canine and posterior teeth, and a palatal or lingual 'spring' to support the missing anterior units, then made from porcelain long pin facings. This was an especially valuable procedure before the days of bonded porcelain, and he built his own hydrocolloid bath so that he could use 'Dentocoll', one of the first elastic impression materials available. His patients would bring over supplies from America. As soon as it was introduced he was one of the first dentists in London to use bonded porcelain, and his technicians Ray Ward and Len Brooker used the early Permadent system before vacuum furnaces were available.

When the new Borden high speed turbine drills were introduced in 1958 he obtained one of the first three imported by the S S White company. Ten years later at the age of 60 he bought one of the first split dental units especially made for supine operating and overnight changed his operating methods to fully seated four handed dentistry. Another advance in the 1960s was the introduction from Switzerland of factory made precision attachments, and 'Tommy' immediately saw the advantages of attachments to join non-parallel abutments and this led to the possibility of making larger fixed-removable bridges with acrylic work on a removable superstructure, and to making free end saddle dentures without the show of clasps.

In his active lifetime Tommy gave hundreds of lectures, including many postgraduate lectures at BDA meetings. He was a natural speaker and needing few slides would always draw a full audience. He loved the thrust and parry of an argument, and fought hard for recognition of his views on various committees. He was however not a politically active dentist in the wider sense. He was too busy doing clinical dentistry to spend time on national committees. However, in 1966 he became president of the Metropolitan branch of the BDA and gave an outstanding presidential address which was later reprinted in the *British Dental Journal* as an article 'British Dentistry Today'. It was an outspoken criticism of academic dentistry and the gulf which was then developing between the teachers and practitioners. This paper was influential in the founding of the British Society for Restorative Dentistry, and he was later unanimously elected to become President. Allan retired from Guy's in 1973 at the age of 65, and continued to produce the highest quality of dentistry until his last day in practice at the age of 79.

One of Allan's great abilities was to see innovations, but these were nearly always within the realm of practical chairside dentistry. He was not a great admirer of much current dental research. He was often very conservative of many new materials, but of course in his hands the traditional gold inlay fitted the tooth without fault and most of those he made had a 50 year life expec-



tancy! He was very critical of the study of rare dental diseases and he called this 'dental philately'. Surprisingly also for someone who had started the periodontal department, and who had one of the first hygienists in practice after the war, he did not set much store on periodontal therapy, he regarded this as a procedure to mainly keep the mouth clean, not as a curative treatment.

He had for many years owned a lathe and workshop and was always able to make the odd bolt or parts for garden machinery or his car, but when he retired he turned his attention more to the accuracy of his machine tools. His patients, who adored him, subscribed to a first class lathe as a retirement present, and at the age of 80 he made a clock, cutting out the gear wheels individually from sheet brass, and was still striving for the highest engineering accuracy. He had been interested in astronomy ever since his wartime fire-watching nights, and this led him to make his own phaeboscope[1], a good example of his intellectual ability at that age.

His main outside interest however was always his garden, first of all at Northwood and then at Shardeloes House at Amersham where he restored Repton's fine garden. He had a great botanical knowledge, especially of flowering shrubs and had a lot of experience of growing them over many years. He knew many of the great gardeners of England with whom he exchanged cuttings and plants. He was however not just a theoretical gardener; even at the age of 80 he could be found up a tree with his chainsaw. His physical fitness was allied to his gardening and it was

quite typical that he started skiing at the age of 58 and within a few seasons was to be found on the most difficult runs. He enjoyed it so much that he visited France and Switzerland once or twice every year afterwards and of course as an adjunct learnt French to a fluent level. This is why he was rarely seen at Clinical Day after he retired because he would often be away to find the last snow of the season.

Allan's wife Jane who died 18 months before him was his support system. Without her devotion he could never have achieved so much. There can also be few consultants who have had the pleasure of seeing their three children graduate from their own school.

Allan Thompson was a dentist in a class of his own. It would not be untrue to say that if he had been able to compete for the Newland Pedley Prize every year from 1930 to the time he retired he would have won it nearly every one of those 56 years.

John McCormack

[1] Phaeboscope—a highly accurate sundial with mechanical and optical correction which adjusts the sun's shadow position to compensate for the uneven speed of the earth along its elliptical path around the sun.

Much of the information in this obituary was taken from a recorded interview with 'Tommy' a few days after he retired.

Dr Patrick Brown

Dr Patrick Felix Edward Brown KLJ, MRCP, LRCS, FRCGP passed away on 29 November 1991.

He trained at Guy's 1937–41 and was subsequently with the RAMC until the end of the war when he returned to Guy's as an orthopaedic registrar. In 1949 he went to Brixton as a general practitioner until his retirement in 1986, having been elected a fellow of the Royal College of General Practitioners in the early '80s.

He married a Guy's SRN, Ann Vala Surtees in 1950, and leaves three children and two grandchildren. He was a prominent member and for a time Master, of the Guild of Catholic Doctors, and a founder member of the Catholic Marriage Advisory Council. In his retirement he was a keen amateur painter and contributed annually to the Medical Art Society's exhibitions.

KB

Who needs nurses?

The Patient's Charter, that part of the Government's *Citizen's Charter* dealing with the Health Service, states to patients, 'you should have a named, qualified nurse, midwife or health visitor who will be responsible for your nursing or midwifery care'. The Audit Commission has simultaneously published a report *The Virtue of Patients: Making the Best Use of Ward Resources*, which discovered that many nurses spend a fifth of their time working as clerks or housekeepers. This meant too little time was spent with patients, and thus made impossible the role of the nurse as proposed in *The Patient's Charter*. The need, on this basis, is for the employment of more domestic and clerical staff. This requires a devotion of more 'spondulics' toward ancillary help, which seems difficult at this time of recession and cash-strapped Health Authorities.

On the other hand, it could be argued that too much money is already spent on the Health Service. It was interesting to note, on the occasion of the *Observer's* bicentenary a short quotation from its original edition of December 1791 under the heading 'longevity': 'In a village, two miles from Honiton, the united ages of the parson, clerk and sexton make 270 years. The duties of these three persons are performed by their respective sons, whose ages united amount to upwards of 180 years. NB There is not a physician near the place!' Maybe there was a good nurse or midwife? For, even the attack on the medicine man, when a recent *Guardian* writer asked 'who needs doctors?' allowed, *inter alia* that 'there are some—nurses—who even do some good'. So let's not rest on our laurels that everyone believes in an expansion of the Health Service, nor ever has done!

In another report that has seen the light of day since the demise of its author, the curmudgeonly late, unlamented Robert Maxwell, it emerged that when he was building his publishing empire and cutting staff in the companies it absorbed, he once took a sideswipe at overabundant staff in the NHS. He suggested that one in five health authority employees be eliminated and this would improve the efficiency of the service. Thus the disappearance of jobs, a phenomenon not presently thought viable, in the NHS was proposed by this master of deceit at one time. Now that the full truth is dawning about his practices, it seems unlikely that this proposal, in direct contrast to that of the Audit Commission's, will come to fruition. If it did it would be a contradiction of the Audit Commission's suggestion that more ancillary employees means release of nurses to do what they are trained to do—care for patients. This report asserted that poor management led to too little time spent on the interactive process between nurse and patient, and the specific recording of this.

The Commission also sought to save money by reducing the overlap of shifts and reducing the cost of senior nurse administration. Nevertheless it did admit that practices in these areas differed widely between various authorities.

So who needs nurses? The impression (gained from both consumers and management studies) seems to be that patients do. And if patients are to achieve this in a successful manner, then nurses need the back up of support staff, in order that their attention is not diverted away from their primary care duty. As the role of the nurse changes both in the community and hospital so must the range of possibilities open to assistants. Of course, judging by some

views, both contemporary and historical, people may not need all the medical services available, but from within the profession it would be foolish to neglect the significance of our own position as cited by the Audit Commission. However we should be aware that some folk may see medicine and nurses, as perpetuating our own longevity rather than theirs!

Denis Cobell

Arsenic and Old Lace

Arsenic and Old Lace, a farce by Joseph Kesselring was the superb choice made by the UMDS Theatre Club. Performed during the last week of the Christmas term, it unfortunately clashed with the St Thomas's Christmas Show.

The time is September 1941. The place, Brooklyn, USA. Fortunately the actors did not try to produce American accents, the most adventurous being Jake Mehta's pseudo German which amused the audience no end.

Two elderly sisters, Abby and Martha Brewster, charmingly poison thirteen innocent victims, with the aid of one nephew who has grand delusions of being the president—Theodore Roosevelt. Their imaginative scheme is stumbled upon by a second nephew, Mortimer, a drama critic, who becomes confused and horrified at the drama unfolding before him. The unexpected homecoming of yet another long lost nephew, Jonathan, with a psychopathic personality, complicates the plot further.

The production was well received by the audience (especially the moments of thought block suffered by a few of the cast), and would have impressed even the toughest theatre critic. The set team produced a very realistic stage setting of the Brewsters' reception room and guided by the skilful direction of Arian Lawrence, the cast created an appropriate atmosphere of farcical realism. Hugo Poncia (Jonathan) and Jake Mehta (Dr Einstein) were in fine comic form as the psychopathic and alcoholic duo.

Amid the overall quality, two performances shone particularly bright. Supriya Basu (Abby) and Elliot Smith (Mortimer) portrayed their characters with delightful ease and conviction. Overall an enthralling production with many a laugh.

Smita Y Patel

The Diwali Show

Having gone to all the Diwali shows over the last few years, and enjoying them immensely, I looked forward to the 1991 show with much eagerness and expectation for several days beforehand. However, after arriving promptly for the show, I was still left looking forward to it with much eagerness and expectation, for although the tickets said 7 p.m., it actually meant '7 p.m. Indian time', i.e. 7.45 p.m. If this was a ploy to make the prospective audience long for the show, it certainly worked, and there was a definite buzz of excitement as everyone settled down into a packed Harris lecture theatre. (Somehow it's not quite the same for lectures—Ed). Many members of the audience were clad in no less fashionably than the models of the fashion show that came later, including some very pretty sarees and some curious shirts. The show began with some great live music and singing, even though I failed to notice the connection between some of the songs and anything vaguely to do with Diwali or even the subcontinent (e.g. 'California Dreaming'). Thus began an evening of great entertainment. A wide variety of items were presented to a highly appreciative audience. There was some superb dancing, classical and more modern singing, and comedy. My own favourite part of the show was the hilarious 'Blind Date' which was very well performed. The clothes presented in the fashion show in the latter part of the evening were an interesting and exciting mix of Eastern, Western and East-meets-West attire, as well as some garments that can only be described as hybrid North East-meets-South West fashion. Interesting as it was however, the fashion show did seem to go on a bit too long.

As expected with any live show, there were a few hitches in the progression of events, but these were handled very well by the two presenters. It was nice to see that the Dental Dean seemed to be having a good time.

The show ended and my shoulders looked forward to a hop which promised some bhangra music. Despite one ugly incident in the bar, the hop was great fun and provided a well proportioned balance of bhangra as well as 'normal' (for want of a better term) hop music. My deltoids were ready to contract and relax spontaneously at high rates until late into the night, but unfortunately the hop finished prematurely.

The only real criticism of the whole evening was the lack of refreshments of any type, although there were good reasons for this, given the price of the tickets. Many people came to the event not having had time to eat beforehand and went straight to the hop afterward, although a number went to eat after the show and did not return for the hop, which was a pity.

In conclusion, the evening was thoroughly enjoyable and I would rate it as good as, if not better than any in previous years. Congratulations to all involved.

SAK

Rugby Club

Preclinical tour report—1991

The pre-clinical tour is always a weekend that is early awaited by many and viewed with trepidation by others as the matches played tend to be hard fought. This year was to be no exception.

As is traditional, the tour party met at lunchtime on the Friday afternoon dressed to match the occasion. New friendships were formed in *next* to no time with whichever tourist you were *next* to, and old acquaintances were renewed with customary vigour. After the arrival of our transport we soon loaded up the buses with our kit and the other beer essentials needed for the journey to East Anglia.

En route the thrill of open-top motoring satisfied most of the party whilst others found refreshment to be their main priority. The lure of Cambridge proved irresistable for half of the party who enjoyed the hospitality shown by the local watering holes, but this led to their undoing as they did not arrive in Norwich until the early hours. Their spirits were soon lifted when Ginger produced a luke warm chicken dhansak and pilau rice which he had secretly hidden. Needless to say, its arrival was appreciated by all on the bus with the exception of Welshy whose bag had been used for storage purposes.

Owing to their lateness, alternative accommodation was quickly found in the form of the minibus which proved decidedly uncomfortable and brought new meaning to the old expression 'no sleeping on tour!'

Saturday dawned and sore heads were gratefully exposed to a full breakfast. The prospect of a hard game, however, soon had blood, amongst other things, coursing through our veins.

After a rather roundabout trip to the University of East Anglia we met our opposition who soon discovered that they would be on the rack from then on. We arrived at the ground to be greeted with the news that the kick off had been delayed owing to a game of ladies' rugby in progress on our pitch. Unperturbed at the bare faced lies about kick off time, one tourist used the extra time to get back to nature whilst others returned to Norwich in search of custard.

On the rugby field Guy's played a game of open running rugby (the number of kicks made could be counted on one finger) and the spectators were treated to a thrilling display of hospital rugby at its very best. After the opening minutes Guy's opened the scoring through a 'Campese' style try from one of the centres. At this stage it must have become obvious to UEA that they would be unable to beat us as not only were we more adventurous with the ball but we also had God on our side.

At half time Guy's had stretched the lead to 8–0, much to the delight of the spectators; even Horace had a cold smile on his face—most unusual. The second half continued at the same hectic pace and after a long period of pressure Guy's were rewarded with another score. The match finished soon after a UEA consolation try with the final score standing at 12–4 in Guy's favour.

After watching England beating the Scots, the boys from UEA made us very welcome in their clubhouse with Guy's coming out on top in the Sumo wrestling challenge and Jig and Womb demonstrating their supremacy at water sports. In the evening we again returned to UEA where Muslim played a rather brief game of pool and Scream sent a colourful letter home.

Many of the Guy's men then went on to a party whilst numerous elder tourists settled for a curry closely followed by bed (or minibus).

The Sunday fixture was against Lowestoft and Great Yarmouth RFC. After a short journey to Lowestoft, where Duncan kept us all amused, we arrived to find that Spotty had not arranged the fixture. Lowestoft quickly arranged a team whilst the skipper did the same. This done, the skipper returned to Lowestoft to bolster his ailing finances whilst the rest of the team enjoyed each others company. On his return Roy sought out his hearty band only to find several players looking rather glazed and one bearing an uncanny resemblance to a Juniper berry. However, with kick off imminent, the boys changed quickly to join the field of battle.

Guy's realised that this was going to be a bruising contest after an early score by Lowestoft, but we replied late in the first half with a try from Skyrme at the end of a powering triple-side-step, double-dummy-reverse-loop, on-one-leg, blind, set piece manouevre. Our supporters raised both their own and our spirits to new levels, and after another score by Lowestoft a period of sustained pressure was rewarded with a penalty ten yards from the Lowestoft line. El tank carried the ball forwards and in an inspired piece of play thundered over the line to put Guy's back in the hunt with five minutes to go. Unfortunately we were unable to lift our game and finished with a two point deficit in what had been a closely contested match.

After watching Sunday's International, several tourists were rewarded in true Guy's tradition and, having conveyed our thanks we again loaded up the buses and returned home to the sanctuary of the 'Shoes' to look back on what had been a most enjoyable weekend.

Tourists: Skipper, Welshy, Beaver, Scream, Womb-spot, Jig, Irish, Serge, Gimby, The Liar, Dumpy, Moose, Victor, El tank, Rustler, Ginger, Parotid, Scotty, Pitpony, Muslim, Cockney, Mekior, Balthesar, Duncan, Horace, Terence.

Steven Pryke

Guy's 2nd XV v Belsize Park 1st XV
Nov 29. Won 31–10

After being abandoned by captain John Spencer, the team was left to find their own way to the Belsize Park cowshed at Hendon RFC.

Despite the gloomy atmosphere and the disused surroundings, the Guy's team were in good heart to avenge a defeat by Belsize Park in the previous season.

The match started promisingly with the wind and slope in Guy's favour. The forwards, although giving away a few pounds, were already taking the game to the Belsize Park forwards, despite the absence of Graham Mehorg, who decided to drive to Hendon via the A3. This early pressure lead to two early tries by Richard Breeze after Worth and Tutton had sucked the defence into the centre. At this point Mehorg arrived and made a limited impact. The Guy's dominance continued with further tries from Breeze, Worth and Gush to leave a half time score of 24–6. (They got one as well).

In the second half the Belsize Park XV staged a powerful comeback taking advantage of the wind and slope, but this was countered by strong Guy's tackling especially by Bates and Simpson. Eventually after a long spell of pressure a skilful passing movement resulted in a Belsize Park try which was not converted.

Guy's now realised that defeat was still possible and stepped up the pace with some powerful mucking and mauling. This then opened out in a beautiful flick passing from Barwell, Giles, Ivil and Bats who scored under the posts.

This halted the Belsize Park's winning aspirations which were finally submerged by a last try from Worth who looked particularly slim and fast all afternoon. This resulted in a pleasing scoreline and the prospect of some great matches in coming weeks.

Team: Gush, Breeze, Tutton, Worth, Bunting, Murph, Costelloe, Barwell, Mehorg, Simpson, Bates, Thallon, Ivil, Giles, Slater.

Guy's Hospital 5th XV v Old Dunstonians
Dec 7, HOP

It was a notable day for the club. The original arrangement was that the 3rd XV would play at 1.00 pm followed by the 5th XV. Barts' Veterans cancelled at an inexcusable hour and for a while it appeared that the president, Terry Gibson would be denied a final push for glory before his departure for the East. Happily, Harry Evans made room for him in his excellent side. Sixteen men took to the field but the referee, normally the 3rd XV captain, James Hawker, would have none of it.

Meanwhile the 2nd XV were *en route* to Portsmouth and probably passed the opposition travelling in the opposite direction to play them at HOP. It began and ended in farce because the UMDS van developed gear problems some miles from Portsmouth and the team was ignominiously towed back to HOP. Many had changed into evening dress *en route* but more of that anon.

The 5th XV decided who would play where, some uncertainty lingering in Harry Evans' mind about his own position. It was a revealing game to those on the touchline who turned their backs on the dour struggle taking place on the 1st XV pitch between Guy's and Portsmouth. The team defended brilliantly for fifteen minutes against bigger opposition. It is strange how many London Old Boy sides include players with South African or Australian accents. One of the Old Dunstonian forwards took a bang and in answer to the statutory question after a sponge down the nape of the neck: 'Who is the prime minister?'. He replied 'Mr de Klerk'. In due course the Old Dunstonian forwards pushed their way over for a score but Guy's answered almost immediately with an excellent handling try in which forwards and backs interlinked. The impressive aspect of the Hospital performance was the running and passing. It was simple and direct and lacking guile. At half time, Guy's had scored two tries and were leading 8–6, the opposition having achieved only two penalties. Richard Holmes scored the Guy's tries, neither of which were converted.

In the second half the Old Dunstonian forwards used their size to better effect and wore the Guy's pack down. Even so, several tight head balls were taken by the Guy's hooker. The pattern of an enjoyable game remained unaltered up to the final whistle. Tom Wolstenholme gained a try for Guy's and the opposition managed a goal and one try.

On the 1st XV pitch, Guy's lost their first league game in a close and fierce encounter. There were no recriminations and even

the referee received a little praise.

After quenching thirsts at the bar, more evening dress was donned and players drifted northward. By this time, Terry Gibson had his worst fears confirmed. He was to be feted at a dinner and would have to tell one of his awful stories again.

The dinner in honour of the president was well attended and lively (aren't they always—Ed). The Boland House caterers served several tasty dishes and Lewis Gibson provided background music. Jane and Terry each received a topee, the latter also being given a folding easel and Manson's Tropical Medicine—a tome that should ensure his luggage to Pakistan will attract an excess charge. The speeches were mercifully brief and topical although the diners insisted that Terry spin a yarn about penguins—one of a series of stories which are now so familiar that the audience mouthed the lines in unison. There are none where he is going, nor rugby for that matter. The question of accessibility to a good pint of beer in a more or less Muslim society has apparently been organised in advance by a recently past president of the United Clubs with connections.

Team: C Golvin, D Fetuns, H Evans (Capt), C Elson, S Levin, M Goodwin, Peter HG, M Gall, M Ansell, S Hughes, T Wolstenholme, P Barwell, M Blunden, T Gibson.

Guy's Hospital — 250 years

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Correction

The December issue of the *Gazette* contained a letter concerning the Brookland museum which was attributed to the wrong person. The letter was sent in by G T Crook, and his full address is 118 Nork Way, Banstead, Surrey, SM7 1HP. Apologies for any inconvenience caused by the error.

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Christmas raffle prizewinners

The *Gazette* raffle was drawn on 12 December. The prizewinners are listed below.

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March 1992

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- The Living Image Appeal—PET centre
- Mr O'Flynn—an appreciation
- Guy's of the future—*Gazette* fiction

We met Mary's in the UH cup semi-final . . .
(**Photo**: Ole Vielemeyer)

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Guy's Gazette

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The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

I am inclined to agree with Dr Pitt-Payne when he says that medicine is a funny old game. Indeed, I think that this should be extended to include life in general. I do apologise for the lateness of the February issue, caused by a delay that unfortunately arose after the passim had gone to press—which serves me right for predicting a return to earlier publication dates. It just goes to show, as Denis Cobell points out in this month's nursing notes, the only thing you can be certain about in life is that you'll die.

I have been following some recent correspondence in the columns of *Hospital Doctor* about patients' right to refuse consent to treatment on religious grounds. It seems that some [Dr Keep—*Hospital Doctor*, 20 February 1992] would assert that 'religious belief has nothing to do with intelligence or logic'. He further claims that religious belief 'is a distorted view of reality irreversibly implanted in the brain by childhood emotional conditioning'. Again referring to this month's nursing notes, Denis Cobell's experience with his 'teddy bear's funeral' suggests that, for some at least, religious disbelief may also lack a rational or logical basis.

From my understanding of psychology, patients' beliefs often affect the way they perceive their illness, and their attitudes during the process of recovery. Many in the caring professions may dismiss the idea of religion, in a similar way to Dr Keep, with an—in my opinion unfounded—air of intellectual superiority. However, in the professions we have chosen to practice, we should still have an awareness of the beliefs of our patients, and the reasons for those beliefs—one may even find those that have arrived at their belief based on intellect.

Given the above points, I find it hard to explain why the Clubs Union takes the attitude that religious societies are not for the social or cultural benefit of the student population. Exposure to, or at least a consideration of the role of different belief systems in peoples' lives should be of use to students in their future careers, and can only be of benefit to patients.

On a different note, the keen eyed amongst you will have noticed a change in the typefaces used. This marks the first issue of the *Gazette* that has been 'electronically typeset'. In these early days we are treading carefully, but any suggestions you might have will be gratefully received. Let me take this opportunity to thank Hobbs the Printers, of Southampton, for their help and advice during the introduction of this new technology.

Charity cricket match

Dear Sir,
I am writing to inform your readers of a charity cricket match at Honor Oak Park on 21 June, in aid of Guy's Hospital Renal Transplant Research Unit. Gavin Campbell is bringing a team from BBC TVs 'That's Life' programme to play against a team of celebrities and transplantation professionals, captained by Mr G Koffman. We are holding a fête at the same time with a celebrity charity auction, arts and crafts stalls and much more.

It will start at 2 pm, and there will be an entrance fee of £2 with children admitted free and free parking available.

Please bring family and friends to enjoy an afternoon out with us. We need all the support we can get—so do please come.

Yours faithfully,

JUNE E SWAIN
16 Marina Drive
Milton Keynes
MK12 5DW

Jim Marsh

Dear Sir,
I have just learned from an old Guy's friend Mike Simpson in Bahrain, that Jim Marsh died in the latter part of 1991.

Jim was the landlord of the 'King's Head' in the King's Head Yard and he and his wife Bette were wonderful to so many of us in the 50s and 60s and after when they went to the 'Duke's Head' in Bromley.

His passing may or may not have been noted and recorded in the *Gazette* before you receive this letter, but if not I hope you can find a space. There must be many people still around who will remember Jim and Bette—they looked after us students like their own.

I would like to take the opportunity of telling you that I haven't missed a *Gazette* in the 30 years since I left Guy's and I look forward to reading it very much. I am glad also that it has reverted to it's old format.

With best wishes to all *Gazette* staff in 1992.

Yours fauthfully,

MICHAEL STEYN (1955-61)
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Platelets in heart attacks

A study headed by Professor John Martin of the British Heart foundation and King's College has shown that platelet size may predict the risk of second and subsequent myocardial infarctions. The mean platelet volume (MPV) was measured in 1,716 men who had suffered a heart attack. The MPV was significantly increased in the 126 men who had another MI compared to those who did not. MPV is a measure of the blood's tendency to clot—the larger the platelets, the greater the tendency. Professor Martin suggests that platelet size should now be considered a risk factor for recurrent myocardial infarctions.

Carpal Tunnel Syndrome—a new approach

A revolutionary surgical procedure for Carpal Tunnel Syndrome, one of the most commonly performed repetitive strain injury operations, was launched last month by Smith and Nephew. Called ECRA or Endoscopic Carpal Tunnel Release Assembly, the procedure is performed using a 'slotted' cannula which allows surgical instruments direct access to the carpal ligament without affecting the surrounding nerves and tendons. Once the cannula is in position, the surgeon inserts an endoscope into one end of the cannula, whilst knives to carry out the operation are inserted into the other end of the tube.

Wasting beds

According to the Audit Commission, the number of beds in acute hospitals could be cut by up to one third without compromising current health care standards by an increase in efficieny. The report claims that 27,000 beds could be spared if the standards set by the most efficient health authorities could be implemented throughout the system. Poor admission, wrong ward placements and lack of proper discharge arrangements are among reasons cited for the inefficiency.

NHS dentist drain

An increasing number of dentists taking up private practice have caused a serious shortage of dentists in the NHS. A DoH survey published last month shows that up to 75% of dentists in some parts of London are refusing to give patients NHS treatment, and throughout London and the Home Counties less than 70% of dentists accept all patients. The BDA said the survey endorsed worries they had been warning against for months, and that they would like to see a scheme rewarding commitment to the NHS.

Litigation—bad for your health

Increasing number of GPs are said to be suffering from serious nervous stress and chronic illnesses as a direct result of increased legal action against them, despite the fact that in 75% of cases, GPs are found not to have breached their terms of ser-

vice. This has prompted the RCGP to call for a tightening of often lengthy FHSA complaints procedures and a comprehensive counselling service to help GPs to cope.

Get the right guard

The December issue carried an item of news about a Guy's security guard being charged with arson at the hospital. Cannon Security Services, responsible for security at the medical school, have been in contact to clarify the situation. The guard in question was employed by the hospital security company, Abbotts, and is in no way connected with Cannon Security. Apologies to Cannon Security for any misunderstanding that may have resulted.

Pressure for tobacco advertising ban

A DoH report last month officially concluded for the first time that a ban on tobacco advertising would help reduce smoking, putting renewed pressure on the Government to bring in such a ban as the EC Countries prepare to discuss the issue again. The document is based on evidence from New Zealand and Norway, and coincides with the finding that smoking related deaths are rapidly on the increase in women, killing 35,000 women a year. In Scotland, lung cancer has already overtaken breast cancer as the major killer of women.

Heterosexual HIV rise

A quarter of people infected with HIV last year caught the virus through heterosexual intercourse according to the latest figures from health authorities in South East London. This compares with an average of 10% of heterosexual HIV cases over previous five years. HIV prevention managers are concerned at the lack of response to the warnings amongst the heterosexual community.

Research award

Dr Heather Milburn, a senior registrar in thoracic medicine at Guy's was one of 500 distinguished women attending last year's prestigious Women of the Year luncheon at Savoy hotel in October. Her invitation was in recognition of her work on the pulmonary complications following bone marrow transplantation. Earlier last year Dr Milburn was awarded the BUPA medical foundations 'Doctor of the Year' research award.

Prize for best paper

Miss Rebecca Liu, one of last year's psychology BSc students and Dr Helen Jones, senior registrar at Guy's, were jointly awarded the Annual Prize for the best paper and presentation at the South-East Thames Society of Anaesthetists Scientific Meeting held on 8 February 1992. Miss Liu's paper, arising from her BSc, was *Effect of stress on postoperative recovery*, and Dr Jones' was *A new endotracheal tube for fibreoptic intubation.*

Horizon plea

The Guy's based Horizon support group for childless couples launched a New Year campaign for more NHS cash to fund the treatment of infertility after doubling its membership in the last three months. The group says as many as one in six couples are affected, yet infertility patients face some of the longest waiting lists in the NHS.

Reunion dinner

The '52 Club (which may include adjacent years) will be holding a 40th anniversary reunion dinner for the 1952 graduates on Saturday 28 November 1992. This will be held at the RAF Club, 128 Picadilly, London at 6.30pm for 7.30pm; black ties. Club members may bring one guest. Further details of club membership are available from the Honorary Secretary, Howard Reeve, Netherton, Leeks Hill, Melton, Woodbridge, Suffolk, IP12 1LW.

Guy's Biennial dinner

The Guy's Hospital biennial dinner will be held on Friday 2 October 1992 at the Grand Hall, Connaught Rooms, Great Queen Street, Kingsway, London WC2. Further details will be available later, but anyone wishing to attend should contact Mrs Barbara Ingarfield at Guy's Hospital, Tel (071) 955 4169.

Clinical Day

This year's Clinical Day is to be held on Saturday 7 March. It provides an ideal opportunity for former dental students to renew acquaintances. In addition, there is a comprehensive programme of events on the state of the art in dental techniques and research with demonstrations and poster presentations. The W E Herbert Memorial Lecture this year will be given by David Glynn on the subject of 'Aesthetic reconstruction using the Branemark Implant System', starting at the earlier time of 9.30 am. Professor Poswillow will also give a lecture on cases that have been sent in.

Memorial service

A service of thanksgiving for the life and work of the late Mr Allan Thompson is to be held at 12 noon on 6 March in the Guy's Hospital Chapel, St Thomas' Street, London. He was Consultant Dental Surgeon Emeritus to Guy's Dental Hospital, of Shardeloes House, Amersham, and 40 Harley Street, London.

"Quote-Unquote"

Two students discussing the Block I Pathology exam:

'The short answer questions don't have negative marking...do they?'

'No—Just negative impressions!'

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Guy's—2092

Medical science friction

Medical science had come a long way by the year 2092—and had stopped, at least in human terms. Diagnostic supercomputers had long exceeded the comprehension of most physicians, particularly after generations of 'machine-built machines', and inevitably a dependency on these machines had developed. Computers were, after all, more efficient, cost-effective and consistent than their human counterparts, with a massively greater capacity for knowledge, and 100% instantaneous recall. How could their judgement be challenged?

It was in this climate that a young, adult, white male was admitted unconscious to Guy's Hospital Casualty Department early one Saturday evening. Casualty Officer Jerry Miles and 1st year clinical student Mike Ross were the first to attend to the patient. After a standard clinical examination, Jerry entered his findings into the bedside terminal, and pressed a small red button. The bed immediately moulded itself around the patient, and various probes sensored in towards their respective locations. The diagnostic computer did its work.

'EMG shows reduced muscular activity. What do you make of that, Mike?'

'Um, possible stroke, maybe just unconscious.'

'Little unfair of me to ask. Too early to say. Iridological readout predicts high probability of epilepsy, occipital lobe. But look at this.' Jerry fingered the EEG report.

'EEG hologram shows high fronto-occipital amplitude gradient. Strange.'

'Jerry, uh, could the computer be w-wrong?'

'Can't be, of course. Ha, do you know how many beds this modem supports?'

'But surely an error like this could be made without a total loss of consistency rating? We're dealing with probabilities and not certainties, after all.'

'Yeah, but the Neuro sector should automatically mesh with the overview. I don't recall anything like this happening before.'

'So, which report should we trust, Jerry?'

'Don't know. I'd better call the Neuro Registrar.'

Some minutes later, Dr Judith Streem entered casualty.

'Jerry, I trust this is important. You've just interrupted some crucial simulations I was going over. I won't get Cray time again for a month.'

'It's pretty important. What do you make of these printouts? I've asked the computer for ratification, and its output remains constant.'

'Jerry, you know I'm not a high-flying programmer, but it looks like we may need to do some more tests. I'll call Rajiv in Neuro Comp.'

'Rajiv Jama, assistant update programmer to the large BRAX 900N mainframe (affectionately nick-named BRAIN) in the Tower Computer Centre's Neurology Section, arrived perturbed at the news.

'Hi Judith, Jerry. Have you double-checked the readout?'

'Yeah, but still no sense. What do you think?'

'I've brought down a BRAX Portascan from the Tower. Maybe it'll help. I can't stress how serious it would be if the Neuro section of the General Clinical program became, uh, error-prone. The program's basically a compendium of our BRAX upstairs, so the implications could be huge. Do you know we even export that program?'

'What can we do?' asked Jerry.

'Nothing, but the Portascan can.'

The compact apparatus was placed over the patient's head, and small hydraulic fingers automatically moved it into position. No-one present quite knew how it worked, except how to connect it up and collect its report. But that was enough, wasn't it? Five minutes later, scans and reports were being displayed and printed out. After studying these and the suggested courses of action, Rajiv muttered to himself.

'Remarkable, remarkable. F-DOG indicates massive frontal lobe glucose utilization. The NMR Neurone Spread indicates considerable neuronal enlargement and dendritic proliferation. Conclusion: BRAX believes the patient to be a child of up to six years of age currently in REM sleep, showing high levels of neuronal lability'

'But that's ridiculous, Raj,' said Judith. 'Either BRAX is wrong, or this is some kind of miracle.'

'But Judith, Factor Analysis confirms high growth factor D&E levels in the CSF. There's no doubt about it, something fantastic is happening inside this man's brain.'

'Where was he picked up?' Judith asked Jerry.

'Other side of London Bridge station by the Dungeon, lying in a gutter. A passer-by reported him. Ambulance-men found no identification, and dental ID and retscan were negative. He is something of a mystery.'

Finally, Rajiv spoke. 'We'd better air-call Prof Duncan, Head of Intelligence Surgery. This sounds like something he would be interested in'.

The patient was left to be nursed by a Drake Care Unit, while Rajiv went to search for bugs in the huge BRAX program. Judith and Jerry went to meet

Christopher Duncan in his office on the 42nd floor of Guy's Tower.

'So', concluded Jerry, 'the computer can't make sense of the patient's current status'.

'But what do you think, Dr Miles?'

'I've long since deferred to computer reports, Prof, because I've been caught out too many times! I see my job as using the diagnostic programs properly, not interpreting them. What's the point when we can deduce only a handful of hundreds of possible diagnoses?'

'Dr Miles, I remember when the first multipurpose diagnostic programs were introduced from Japan, and we all know their benefits in terms of cost, accuracy and so forth, but what about their drawbacks? We seem to have become little more than technicians, delegating our responsibility to their 'superior' intellect. Has it gone so far that you can't even offer me an opinion about one of your patients?'

'But surely, Professor, medicine has benefitted from their use? And why does one case of possible mis-diagnosis cause you such dismay?' interrupted Jerry.

'Jerry, you fail to see the fundamental point. An unusual case arises, one which your computers fail to make sense of, and you simply fail to cope. You run to others with supposedly more skill, and they do the same. What has happened to human ingenuity and flexibility? In my day, if a doctor had an unusual case, he would study it, get advice from others, certainly, but would write a paper or give a lecture to describe the new phenomenon, and in this way come to terms with it.'

'I see your point, Professor,' Judith interspersed, 'but no new cases have arisen for years. Since the human genome was mapped over 50 years ago, all possible genotypic variations have been predicted and explored. Humans are no longer qualified to pursue research without computer guidance.'

'In that case, Judith, your current patient has rather put a spanner in the works.'

Professor Duncan could have made a fortune if he had opted for childhood intelligence induction in the private sector, but he chose to remain in what was left of the National Health Service, doing neurone manipulations in mentally handicapped patients, and element replacement in head and spine injury victims. He was sure the patient showing frontal lobe development was a unique example of neuronal lability in an adult, which had some exciting implications, but, more importantly, he hoped to use this case to highlight the inadequacies of a purely automated hospital, and halt this so-called progress before it was too late. Would there be anything left for us to do, he thought. We don't even build the machines anymore. And at the back of his mind, he

feared where the evolution of artificial intelligence would end. When would computers develop a... a consciousness. And what would they do then, given that they already had almost complete control over humanity. Yes, things had to change, and soon.

On the third day of the patient's stay, Professor Duncan completed his daily business round by examining 'the patient'. Before a huddle of medical students, he described with the aid of the bedside holographic monitor the patient's prodigious history. As he spoke, however, all eyes turned away from him as something quite unexpected happened. The patient opened his eyes, smiled, and sat up. This should not have occurred if the bedside modem's indications of EMG status were to be believed, but it had. Christopher Duncan stood, mouth agape, as if in a dream, as the patient slowly turned towards him, and spoke.

'I have risen again. Something wonderful is going to happen.'

But at Guy's Hospital, which had always been a trend-setter, it already had. One of the most important symbolic figures of humanity had returned.

John S Gilbody

The Living Image Appeal for UK Clinical PET

The Florence Nightingale Fund's first project

The Rt Hon The Viscount Whitelaw chaired a press briefing for the Living Image Appeal which has been launched to fund the first British Clinical PET (Positron Emission Tomography) Centre, to open at Guy's and St Thomas's Hospitals.

PET has long been a research tool at the Hammersmith Hospital, and there are approximately 60 centres in the USA, with a further 40-45 programmes outside the States. Imaging is achieved by scanning for the distribution of selected radioisotopes (introduced by injection or inhalation) relevant to the function of the organ/tissue to be studied. PET thus gives a functional image, as opposed to the structural images offered by computed tomography, magnetic resonance and ultrasound techniques.

Clinical situations which may benefit from PET outlined in the briefing included: assessment of damage to the myocardium in ischaemic heart disease; establishing the site of epileptic foci; early differentiation of Alzheimer's Disease from depression (figure 1); and differentiating a functioning mass, such as tumour, from a non-functional mass, such as scarring (figure 2)—which may be indistinguishable on CTs or MRI.

Questions were raised at the briefing about the funding and running costs of the Centre. The Living Image Appeal aims to raise £5 million towards establishing this Clinical PET Centre though the services of the Centre will only be available in the same way as other Trust services. However, funds collected by the scanning of private patients and from extra-contractual referrals will be utilised by and for, the Centre, whilst the anticipated academic projects will be supported by research grants. In the future, when other London hospitals hope to have scanner facilities, use of the Centre's isotope generator is anticipated to be another source of income.

The Centre hopes to start scanning patients from April 1992, seeing 8-12 patients a day, with each scan costing approximately £300-£600. Each hospital will have scanner facilities, but the radioisotope generator will be based at St Thomas's.

There was considerable feeling at the meeting that PET will be optimally exploited as a clinical and academic tool, in this joint venture between Guy's, St Thomas's and UMDS.

For further information about the Florence Nightingale Fund contact Derek Robertson/Louise Hominick on (071) 928 9292 ext 2213/3401/8057.

HM

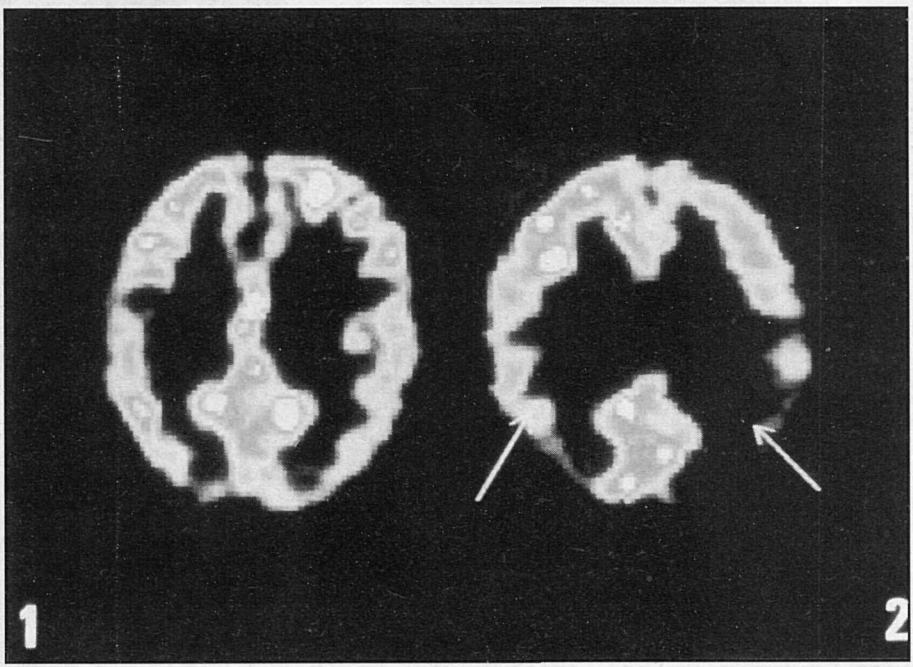

Figure 1. PET scan of a normal brain (1) and the changes seen with Alzheimer's disease (2).

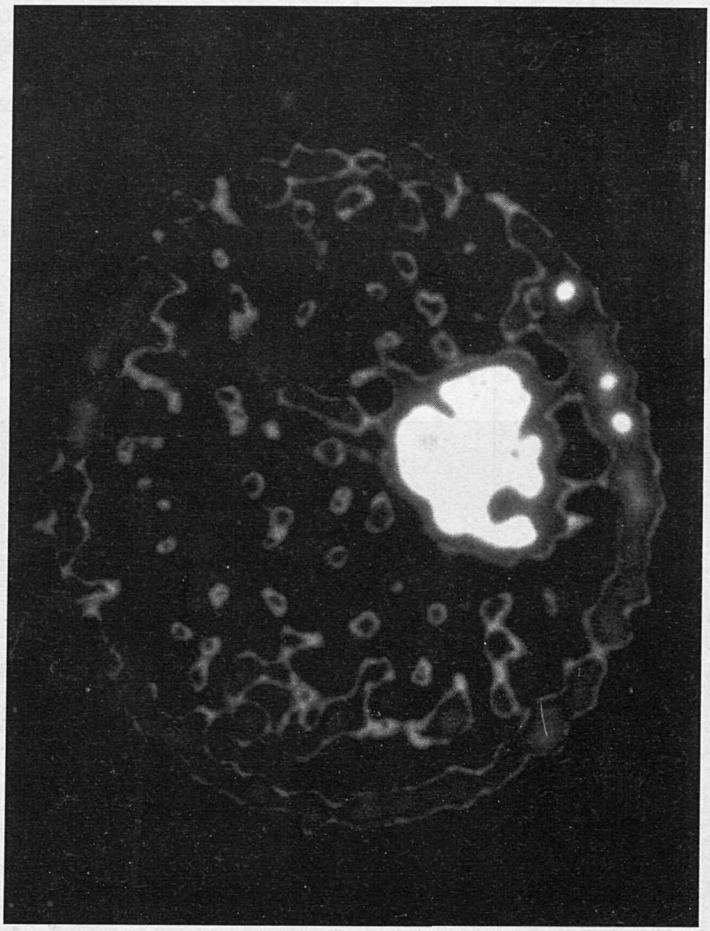

Figure 2. Brain PET showing increased metabolism due to tumour

Guy's Hospital Gazette

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The Big Sleep

Anaesthesia as she was

When Lord Nuffield announced that he would be endowing a Chair in Anaesthetics at Oxford he was told that there was little point in it as anyone could give an anaesthetic. He is reputed to have said: 'That's just the trouble.' My spell in anaesthetics at Guy's is rather more a blur than it should be. I have been on the receiving end five times now and even in my short lifetime things have come a long way since my first dental gas with a Walton Number One apparatus. This rather hideous-looking contraption bore a striking resemblance to that other thing the Americans landed on the moon—with people in it. The controls were extremely crude and I would never have had the nerve to use the thing had it been me. My father, Frank, could do three dental gases in fifteen minutes with the patients—usually children—walking away from the chair and never being sick. The trick, he told me, was to give 'em straight nitrous oxide with a squirt of oxygen right at the end. Such things depended on the dentist moving pretty sharply with his forceps, and for years he managed without any problems. He gassed me on three occasions and I am still here to tell the tale. The reason the dentists moved so fast was due to the rather alarming cyanosis which developed using this technique. With 98% nitrous oxide and 2% oxygen, he said, the kids were invariably sick afterwards. The important thing—as far as I was concerned—was to go under without a fight. On the first and third occasion I managed this, but the middle event was less easy and I did struggle a bit and didn't feel too hot afterwards! The tooth fairy usually got the sack after these multiple extractions and I'd get five bob—not bad for doing nothing!

In days gone by, many procedures were not done with anaesthesia and my mother's father used to regale us with the occasion of his tonsillectomy. They were guillotined with him sitting up in a chair and the doctor gave him a shilling for being good. My grandfather, Dr William Pitt-Payne, gave my father a straight rag-and-bottle ether induction when he got appendicitis in 1926. This operation was done on the kitchen table at London Road, Bromley. Dr Dorothy Gibbs, the ex-nanny-to-the-family-turned-GP, continued with the anaesthetic and the operation went without a hitch although my father reported severe vomiting post-operatively—which was very unpleasant. He got to keep his appendix which was kept in a bottle and in due course he swopped it for some

puss-moth caterpillars. Such was life in the good old days. I suppose it's rather frowned upon to be medically incestuous these days but I was delivered by my uncle, L G J Pitt-Payne, and he delivered everything going in my generation. His own children were delivered by his father, the aforesaid William, my grandfather. Uncle Leonard, as we called him, did a Sunday morning tonsillectomy round before the war with my father doing the gasses. Naturally, all this was done on the kitchen table with the gag and such like.

Prior to going on the wards at Guy's, I'd spent a couple of nights on Esther Ward having my eights removed. Mr D M MacDonald did this for me. I remember being wheeled into the anaesthetics room in Main Theatres and waiting for the anaesthetist who was either finishing someone else off or getting ready for me. A dental student asked me who was whipping out my teeth and I said: 'Mr MacDonald, of course.' His reply was a bit unnerving: 'Not, Mack The Knife!' Well—it all went terribly well and that little nerve, the Chorda Tympani, which we all worried like hell about in case it got damaged when digging for impacted eights was as right as ninepence. Most of the students went to Don Gibb who was senior registrar and a lightning operator. There were dental gas sessions in medical outpatients which were attended by medical and dental students together. We did the gas and our counterparts did the extractions. Sometimes, the tooth broke and it was Mr Gibb who suddenly went in with a truly gruesome-looking metal instrument; whipping out the remains of the tooth in one swift movement. One could but gasp with a mixture of admiration—and disgust—because it was a messy job, but someone had to do it.

Anaesthetics produced its own brand of characters and my favourite was Dr David Carnegie who had a delightful line in pre-med patter. He was blessed with a voice that fairly purred and a nasal quality akin to the late Kenneth Williams so that one was reminded of happier times; Sunday tea on the lawns, croquet, and all that kind of thing. 'Don't worry old chap/my dear—everything is going to be ab-so-lute-ly fine'. It was delicious—and we'd all like to have done it. He was the archetype of the soothing we're-going-to-send-you-off-to-sleep anaesthetist. He was rather more than that, of course, and was completely at home in the early versions of the high-tech surgery going on in Theatre One in New Guy's House—the high altar of surgical technology as I think of it.

There was Dr W S McConnell who put me in mind of the late Miles Malleson, the actor. He was the epitome of good old-fashioned courtesy and very definitely a member of the old school. I'd have felt quite safe being given a gas by him. I received my last induction from a senior house officer who had, I was told afterwards, the very devil of a job getting the tube down my trachea

having passed it up my nose. I wondered why I had such a sore throat afterwards. The Brietal induction was great, though, and a considerable advance on what I'd been subjected to over the years.

We watched various ECT sessions. It was odd to see that kind of thing being done. It had a medieval flavour to it and I was very glad that someone published a paper showing that patients were just as well for being put out whether they'd been shocked or not. I'm sure there's someone out there who'll put me right on this matter—but I felt it was one up to the patients. They have as much right to get better because of us as in spite of us.

Patients in the private sector are frequently somewhat taken aback at the size of the anaesthetist's fee but until their fees and those of the surgeons reach parity, honour will not have been satisfied. I don't think that the likes of BUPA, PPP, BWCA, and WPA would take too kindly to it, but it's only a matter of time. Anaesthetics has come a long way in a hundred and fifty years.

There are the stories, and they probably recur with every generation. One lady awaited in the anaesthetics room for a senior registrar to come and perform a sigmoidoscopy. The anaesthetist was there at the head of the bed and the luckless doctor, assuming the patient to be safely asleep, said: 'Well, Madam, how'd you fancy thirty centimetres of the cold steel up your bum?' What followed, I cannot remember, except the anaesthetist announced with considerable aplomb: 'The patient is awake.' Whereupon a certain jaw dropped. One should always be careful of what one says in theatres as one never knows who might be listening!

I had a young doctor in my office the other day—but not biblically you understand—and she told me she was thinking of a career in anaesthetics. She was on her way to Part I MRCP and then onwards to the FFA. It's all a far cry from the funny metal thing I've got which opens up and holds a piece of lint onto which the doctor dripped ether a bit at a time.

Every abdominal scar has a tale to tell. A few years back I saw a very ragged appendix scar on the abdomen of a very senior lady. It was a forerunner of the gridiron incision by the looks of it and I, with my usual clinical tact, pointed at it and said: 'What the hell happened to you?' It transpired that no less a personage than Sir Alfred Fripp KCVO had removed her appendix in 1908 at Guy's—in the days when it was called phlegmonitis—and one could see that there had been healing by secondary intention with plenty of the good laudable pus to boot. It was one of her proudest possessions and I duly marvelled at this piece of surgical history writ large over what was to become known as McBurney's Point. Dr George Scott saw a similar sort of scar once and asked the patient where the operation had been done, and on hearing it had been done at Brighton, he replied: 'Where? On the Beach?' The point was,

of course, that there was no curare to relax the muscles and everything was a bit of a struggle especially when it came to getting 'it' all back into the abdominal cavity.

It's a long time since I went into an operating theatre; the main reason being that there's nothing they've got that would fit me any more. But in the days that I did scrub up—the kiss of death for the patient—I could see that things were getting better and better and now I see them coming out of theatres—the patients, that is—looking quite pink and I can talk to them—if they're awake—and they seem sounder in wind and limb than ever before. The days of looking like death warmed up have passed. As for myself, I am left at the end of this piece thinking what anaesthetics did for me as a student of the '60s—and it is this: I was taught how to give an intravenous injection and set up drips, and these skills proved invaluable for what came later. I also learnt all about cardiopulmonary resuscitation which was a relatively new thing then. My last encounter with this particular facet of my ability left me with a mouth covered with bright red lipstick and a funny taste. There's no doubt about it—medicine's a funny old game.

J H Pitt Payne

Mr O'Flynn

An appreciation

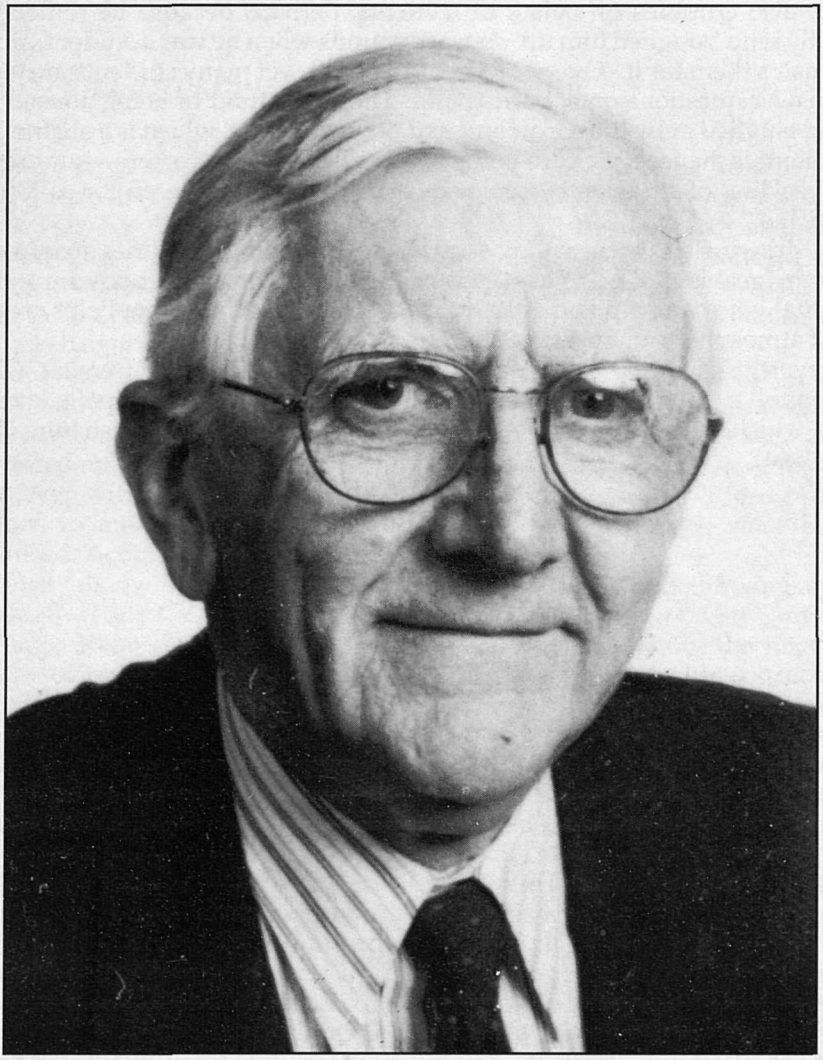
Mr O'Flynn is chatting with the staff nurses in outpatients as I finally catch up with him. He is coming to the end of a long career at Guy's, dating back to the 1960s, still well liked by students and still talked to by the anaesthetists. He is quite strikingly tall, strangely contrasting with his mild Irish accent, and the glint of humour in his eyes is frequently evident.

He looks back to the early days in Ireland, where medicine was a part of the family tradition, and where they presided over a general practice in County Limerick (which had been in the family for 80 years). The career decision seemed to be easy. 'It looked a marvellous life, being a doctor, and I didn't want to do anything else.' That decided, he felt a natural inclination to do surgery after seeing some in Dublin, even though the surgeons were 'pretty vicious to the students,' a point to which he returns on a number of occasions.

As a student in Dublin, the training was much more practical than theoretical. Mr O'Flynn suspects that if he had been a student now he would have never got into Guy's (and this, he says, makes him wary of sitting in judgement of students who would have certainly got better 'A' levels than him). The emphasis on clinical training now, he feels, is probably due to the explosion in medical knowledge, and this has meant that students today have been led into studying all sorts of specialities at the expense of basic medical principles. Yet, back in Dublin, they had plenty of experience on the wards, and it was from that time that Mr O'Flynn's career took off. It is difficult to believe that he was as lucky as he claims—that he was simply in the right place at the right time when the job openings were there. It is either his typical modesty, or the luck of the Irish at play here. Mr O'Flynn also impresses with his very human qualities. He is genuinely upset by the fact that junior doctors seem to be leaving medicine in greater numbers. It is a point that he has obviously dwelled on in private, and to which he would like to see a solution.

'The junior doctors are unhappy not just because of the long hours, but also because of the disgusting conditions in which many of them live—no hot food available, living in a box room without windows, a telephone at the end of the corridor and bed linen that isn't changed.'

'If the juniors had a bedroom with a bathroom and sitting room *en suite*, meals when they required them etc, they probably wouldn't be so bitter about



Mr O' Flynn

the long hours. It's terrible to be on call for the whole weekend and then have to send out for a Chinese takeaway on Sunday night.'

He also crusades on behalf of students, perhaps because he remembers exactly who 'roughed him up' on ward rounds when he was a student, and he still hates them for it. 'One shouldn't generalise, yet many students are afraid to answer questions on a ward round. They are afraid of being abused and being laughed at by the consultant and other students, which is a shame.' Yet despite this, he feels we turn out some excellent young doctors—'and really, the heckling of students by senior doctors has been going on for as long as medicine.'

So, drawing his career at Guy's to a close, his abiding memories are of a very knowledgeable and cooperative people. 'There's always somebody around the hospital who can help you with a particular problem, and that helps create a good atmosphere amongst the staff.'

Nevertheless, Mr O'Flynn is looking forward now, to his retirement, which will involve walking, music, theatre and no medicine, but principally keeping bees, which is something he's had in mind for some time. We wish him all the very best.

AMS

The Bore Report

Eating and drinking—the essentials of life

As I have suspected for a considerable length ofo time, despite what others have said, hospital managers are not completely anencephalic. This has been conclusively proven to me by the earth shattering decision to keep the Spit open until 2 am. The fare available at this time includes cooked breakfasts and evening meals, and provides a much more palatable finalé to an evening of entertainment in the basement of Boland House than does a kebab or curry.

However, having sung the praises of the Spit, I must point out that it does have its downside. Recently I have worked at two other London hospitals; Lewisham and the Brook. I wonder how it is that the canteens at both these celebrated medical establishments can sell food for half the price that the Spit does (even with a UMDS card). Still, being a staunch Thatcherite, it is plainly obvious to me that great things have happened in the Spit since being privatised. Actually, that's a lie—its not that obvious.

Whilst talking of prices and value for money, I cannot help thinking about the bar. Recently the student responsible for running the bar—Guy's answer to Gengis Khan—has been showing how worried he is about the financial welfare of the students that he represents. He has shown his concern by advocating a twenty pence price rise accross the board. This would make a pint of bitter cost between £1.20 and £1.30, and a pint of orange juice cost 80 pence. When I was on the bar committee, we used to work on a 40% mark up and even then we only charged 70 pence for a pint of bitter. In the intervening period, prices in the bar will have almost doubled whilst pub prices have only slightly increased. As a pint in the Horseshoes can be acquired for only £1, may I suggest a bar boycott (I already do—Ed) if these outrageous price increases are pushed through. Brothers, we must stand firm if those who we chose to represent us are not fulfilling our expectations of them.

On a different note, how nice it is to see a sparkling Shepherd's house emerge from under its layer of grime. Would it be possible to give Old Guy's House the same treatment or even Henrietta-Raphael House (the nurses home for you peasants out there) as it looks rather ridiculous perched between the Medical School and Shepherd's House.

Cedric Bore

The Rotunda Hospital

Deliveries in Dublin

During the late forties and early fifties a discreet advertisement appeared regularly in the *Gazette* inviting undergraduates and post-graduates to attend courses of training in Midwifery and Gynaecology at the Rotunda Hospital, Dublin—apply to the Master!

As home deliveries on the District at Guy's were already diminishing in number, in November 1951 John Rozario—a fellow student and, like myself an ex-Sapper—entrained at Euston Station *en route* for Dublin.

Our first mistake was to travel third class on the boat from Liverpool, the second was to pick the longest crossing by boat to Ireland in November and our third was to decide to walk from where the boat docked to the Rotunda. The combination of these matters was nearly the undoing of us before we had even started.

The first weekend was taken up with gathering around us the necessary kit—hiring a bicycle and purchasing silver-plated catheter—and carrying out the two statutory deliveries under supervision before being released on to the district. Now the labour ward at the Rotunda was like no other seen (or heard) before or since.

There were about ten 'stations' partitioned off incompletely with curtains, all seemed to be constantly in use and it was there that we first encountered a phenomenon typical of both Irish and Italian ladies in labour. They do not believe in suffering in silence and the cries of 'Holy Mother of God!' raised the roof perpetually. All this was supervised by the equivalent of a Regimental Sergeant Major of the nursing hierarchy. I suspect that she kept the Master in his place! That being said, once I had used the Rotunda method of delivery, I never returned to that which I had been taught at Guy's. Similarly, it was some years before the early use of iv Ergometrine, as used at the Rotunda, was adopted at Guy's.

For work on the district the system was that two experienced students and two tyros (us) made up a squad. Of the three experts who were to be our mentors, one was an alcoholic, another had TB and was excused night work and the third could not ride a bicycle. After several episodes which demonstrated our betters' manifest lack of organisation, we were left to ourselves as a two-man squad.

Rather in the manner of the Army, rules were laid down to cover emergencies. There were two Clinical Clerks (SHO/Registrar) to whom we had to refer if in difficulty. One of these was Carl Mullen, the captain of the Irish Rugby XV and therefore seldom available. The other, Brophy by name, was also difficult to contact as he was usually doing two people's work. It was he who told us of a patient of his acquaintance who had been married for twenty odd years and, during this time, had had a child once a year and no periods.

The 'rules' dictated that, for certain emergencies one had to return to the hospital to seek assistance but, for others of a life-threatening variety, one could use the telephone. On the one occasion, an ante-partum haemorrhage, that we decided to use the phone, the experienced student who went to do so, returned first because he had no money and again because he did not know the address of the patient. Fortunately the APH was of the short, sharp variety and no harm ensued.

Our first case was a breech which regrettably we were slow to diagnose and which ended in a stillbirth back at HQ. The next one, as I recall, occurred in the middle of the night in an area which recently featured in 'The Commitments' (if you have not seen that, you haven't lived) and concerned a girl in her teens who produced, in the filthiest and most squalid of surroundings, a dead foetus of about 24 weeks gestation whilst a two-year old sat at the end of the bed and watched it all. In the middle of the dirt and delapidation was the latest design of gas cooker in mint condition.

These were the only cases that ended tragically I am happy to say. There were many amusing experiences however. On one occasion we had to go to a flat on the fourth floor of a tenement. As we were in the act of padlocking our bicycles we were strongly advised that, if we left them there they would be stolen—there appeared to be no option but to carry them up with us. On another occasion we administered the statutory enema and called for the bucket only to be told that there was no bucket. Within seconds, during a contraction, the enema was returned, with force, into the middle of the room. Then the lights went out! As nobody had the necessary coinage to replenish the meter, the delivery took place by the light of a pen-torch and was perfectly straightforward if in a somewhat fetid atmosphere. When light was eventually restored we noticed, for the first time, that grandma was sitting in the corner and had witnessed all.

The need for precautions concerning infestation became apparent when a flea walked from my sleeve on to the back of my hand one morning during breakfast. At about this time an Australian post-graduate took a blowlamp to his bedframe in a desperate attempt to confirm his theory that the 'bastards' lived and bred among the springs. We dealt with the matter ourselves by

converting one of our wardrobes into a decontamination chamber with a mixture of Gamaxane and DDT.

We also attended 'miscarriages' as they were called. Many of these, according to Dr Brophy, were due to itinerant abortionists. Students from Trinity and UCD had to amass a number of 'cases' to complete their course. An abortion only counted as a case if 'products of conception' were produced in evidence. As we were under no such obligation, neither jam-jars nor surreptitious visits to the butcher were necessary.

Fathers were conspicuous by their absence during parturition in Dublin. A fleeting visit to the desk to advise that 'Me missus' time has come' was all that was ever seen of them—occasionally their departure was so rapid that the porter had to chase them down the road to ascertain the missus' name and address. By contrast, in all these desperate circumstances, we acquired a lasting respect for the unfortunate women whose fortitude and good humour were constantly evident. We heard little in the way of complaints.

In retrospect the experience was invaluable. Midwifery with limited back-up was what it was all about. Concurrently one learned some sociology. Poverty did not necessarily mean filth. Catholicism did mean that poor people had more children than could be coped with. Constipation occurs in direct proportion to the number of people using the same WC—and so on.

God knows what the MDU *et alia* would have thought of it all but, of course, people were not so keen on revenge in those days as they are now. Nor were they so avaricious.

To all this there was a very happy ending. One of our number—a Chinese post-graduate—bought a new car. We, that is, to say about six of us—went for a trial run. By way of Killiney Bay, we found ourselves in the Wicklow Mountains. The beauty of the countryside would 'take the sight out of your eye' as they say in Ireland—happily it has continued to do so on visits ever since. John Rozario has, in fact, spent a large part of his working life in Ireland.

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Going for Hitler's Jugular

The Dental Corps bites back!

Our CO Major Stuart gave us the news. We, and officers like us, from the whole of Scottish Command, were summoned to Edinburgh by our Director of Operations, Colonel C. It was December 1944, the war was entering a critical phase.

We entrained at 08:30 hours at Glasgow station, all in service dress, buttons and leather glowing. It was a chance to wear my new greatcoat; it came nearly to my ankles and weighed a ton, but the occasion seemed to demand it. Only one officer, junior to me, was left behind to, as it were, hold the fort.

ETA Waverley Station, Edinburgh was 10:15 hours and we arrived on the dot. The meeting was not until 11:30 hours. 'Coffee', ordered Major Stuart and led us into the North British Hotel. The waitress served us with deference: a group of officers with a war weary Major at the head of the table made a pretty impressive sight I felt, from my place at the bottom of the table.

At 11:25 hours we paraded at the RV—the Metro Cinema—as laid down in Major Stuart's confidential orders. We filed in amidst a multitude of fellow officers. Some had come from as far afield as Inverness or even the Orkneys. Major Stuart spied a number of acquaintances, hard bitten men with years of service behind them. I knew no-one, and instead sat next to Major Stuart, basking in reflected glory.

At 11:30 precisely, a hush, the door near the stage opened suddenly and, preceded by a major with a clip board in hand, Colonel C himself appeared, a re-incarnation of Colonel Blimp, but dreaded by all none the less. We scrambled to our feet. He stood by a vacant seat in the front row, glared at us fishy eyed and exploded with one word:

'Sit'.

We sat. Now for it. What we had come for: what probably lay ahead for every one of us. The moment was tense: I clutched the arms of my seat.

'Gentlemen', he began, but didn't look as though he meant it, 'you are here today to see the first showing in Scotland of the new Army Dental Corps film—"Your Teeth". This film will be used to educate the soldier in the care of his teeth and it is your duty to see that he does so.'

So that was it. The promised break-through; that was the meaning of the summons. Travel warrants had been written, allowances claimed, for some,

sleeping carriages had been reserved—to get us all here on time for 'Your Teeth'. If there was toothache in Scottish Command on that day, it was up to the remaining very junior duty officers—holding out determinedly against all odds, dotted about the whole of Scotland—to sort it out.

Hitler, crouched in his bunker, may well have despaired when he heard the news. The Britishers were going to put the bite on him at last, and the Dental Corps was going to see they did it.

Donald Dawson LDS RCS
(Guys 1940-1944)

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Physiology Illustrated. Olof Lippold and Barbara Cogdell. Published by Edward Arnold, London. Price £11.99
Illustrated Physiology. B R MacKenna and R Callender. Published by Churchill Livingstone, Edinburgh. Price £12.95.
By coincidence these two books arrived almost simultaneously for review by the *Gazette*. The one emerging from the Scottish stable is the fifth edition, whilst that from the South is the first edition.

Olof Lippold taught Physiology to me in the 1950s and has long been an innovative teacher always trying to appreciate the student's difficulties in understanding his subject. I well remember him, during a lecture on reproduction, producing from his pocket an amputated and preserved penis, which he slapped on the bench to emphasise important points of the lecture. His latest attempt to help those students who may learn more easily from diagrams than from written text is a book presenting the basic facts in a well drawn series of line diagrams, linked by a modest amount of text. All the standard figures are here—the oxygen dissociation curve, pressure changes in the heart, the pathways in the stretch reflex—and a whole host of new and original diagrams.

MacKenna and Callender adopt a different approach. Each of over 250 pages is a self-contained diagram illustrating specific points of physiology. They are grouped in systems and generally the pictures follow a logical sequence. There is no narrative text to link the figures, but each diagram is well annotated. By contrast with it's competitor, there is liberal use of colour.

How may students find these books useful? Either book could be used in conjunction with a standard textbook but not as a substitute. Students may find Lippold and Cogdell's book a useful introductory text, and I would recommend the early section on Cell Biology for those students who have not done biology at 'A' level. I must emphasise that neither book in isolation has adequate depth or scholarship for the UMDS course. I will adopt many of the diagrams as teaching aids.

F J Imms
Senior Lecturer in Physiology

Histology and Human Microanatomy. 6th Edition by P S Amenta. Piccin: Padova.
Every year or two another general histology book comes on to the market, addressed to the large population of students in medically-related courses. Occasionally these offerings are major landmarks in scholarship, presentation or exposition. Many of them are essentially re-workings of old material, with relatively little new to say, apart from some factual updating.

Revising a textbook which has already gone through several editions is particularly problematical. Is it to be completely revised, or just sprinkled with new material? Dr Amenta has inherited a text written in the traditional mode, with an emphasis on structure, classification and terminology. When it first appeared, under the authorship of Hans Elias, and John Pauly, it was remarkable for Elias' paintings and drawings which illustrated various histological concepts, most admirably the organization of the liver. Six editions later, Dr Amenta states in his Introduction that he wishes to pursue the same noble aims as the originators of this text, namely to avoid encyclopedic detail, direct students to the literature, discuss challenging issues, and help the reader

appreciate three-dimensional microstructure.

He has obviously fought hard, and deserves good marks for effort, but the overall impression is of single handed combat against overwhelming odds. Certainly he has updated the text to some extent, cited newer references and introduced some new pictures. there are however many errors of fact (eg the method of freeze-fracturing is said to involve drying the specimen first), many poor illustrations and a liberal sprinkling of typographical mistakes ('sandwitching' is a rather nice one), all of which make the book a weak competitor against several other contemporary histology texts of a similar price. There are one or two interesting features, such as the final chapter on methods of morphometric analysis (interesting to research workers, if not to undergraduates), and Elias' pictures remain (though many of them now look very outdated). The cover of the book offers the promise of many histological delights within; sadly this hope turns out to be a disappointment.

LH Bannister
Reader in Cell Morphology

OBITUARIES

Peter Ellis

The dental profession has lost one of its more colourful characters by the death of Peter Ellis, at the age of 77.

Son of an Oxford bank manager, he entered Guy's with me in 1932 and our careers were to be closely linked until the outbreak of World War II. A formidable second-row forward and no mean golfer, he was also an excellent clinician and won second and third year prizes. As a young man Peter was always forthright, indeed somewhat abrasive, but his loyalty and puckish sense of humour endeared him to us all.

After qualifying and house appointments, he proceeded to North Western University, Chicago, to get his DDS. I joined him there in 1938, having fortuitously been awarded the Montgomery Ward Scholarship; this should have been given to Peter but he was completely without rancour and we remained firm friends.

After graduation we drove an old banger across the USA—our accommodation being the car and two sleeping bags. Selling the car in a street market in Seattle, we took ship, steerage class, from Vancouver to New Zealand for further adventures and to look for work. This odyssey was cut short by the declaration of war just as we had landed in the South Island. Two jobs then came up—one in Nelson and the other in Singapore. Peter took a coin from his pocket and asked me to call. It was to be heads for Singapore (Peter)

and tails for me (Nelson). I won the toss and the rest is history. He was of course captured by the Japanese and was at that time acting as an anaesthetist in the Malayan Defence Medical Service. The next three and a half years he spent as a prisoner in the notorious and dreaded Changi gaol. It says much for his resilience of character that he survived with spirit unscathed—but Peter was never lacking in courage. Nevertheless he suffered damage to his health from which I think he never really recovered.

After the war he went back to his roots in Oxford and joined Mr Taylor in Keble Road and later establishing his practice in Moreton Road where he was until his retirement.

Peter Ellis was a meticulous operator, a perfectionist, never content with less than the best. He was a member (and past President) of the Oxford Branch of the BDA for forty-three years and took a leading part in its activities. He was a member of The American Dental Society of London and was elected President in 1984-85.

He was blessed with a very happy family life and was a wise and gentle father. We shall all miss him and we extend our heartfelt sympathy to Lyn and children Gillian, Robin and Simon.

Tom Debenham

Dr Ian Mackenzie

Generations of Guy's doctors will be sad to hear of the death after a long illness, of Ian Mackenzie on 25 December 1991.

The son of a distinguished physician in Glasgow, Ian Carville Keith Mackenzie was educated at Rugby School and Cambridge University, returning to Glasgow for his clinical training. He graduated in 1938 and after holding a House Surgeon appointment at the Victoria Infirmary he was on active service with the RAMC from August 1939 until January 1946, reaching the rank of Major. He was subsequently awarded the Territorial Decoration. After the War he resumed his interrupted career and following appointments as HP and Medical Registrar in Glasgow he decided to devote himself to neurology and spent the years 1948-51 as HP and then RMO at the National Hospital for Nervous Diseases, Queen Square. In March 1951 he became Chief Assistant to the Neurological Department at Guy's and in 1955 he succeeded Sir Charles Symonds as consultant neurologist.

He was fortunate to have these years of association with Symonds, for there was an affinity between them in their approach to neurology that was very fruitful and although to follow the most distinguished neurologist of his time was no doubt a daunting prospect in the event he proved to be a very worthy successor, and patients, colleagues and students have reason to be grateful for the outstanding service he provided over many years. He was the first Guy's neurologist to hold sessions in the region and this proved to be a very happy association (still fortunately being continued by his successor), not only providing a first-class neurological service to the Maidstone District but enabling him to teach at undergraduate and postgraduate level on the wide variety of patients transferred to Guy's for further investigation. He had a prodigious memory and outstanding diagnostic acumen and the high respect in which his opinion was held was shown by the many former registrars who continued to turn to him for help over dif-

Dr Ian Mackenzie

ficult problems. He was always a delightful colleague and a staunch friend.

Essentially a clinician he was not a prolific writer but his study of the clinical presentation of cerebral angioma was a major contribution to the subject and his method of testing taste by electrical stimulation has stood the test of time. He was responsible for the neurological sections of several editions of French's *Index of Differential Diagnosis* and *A Short Textbook of Medicine.*

He retired in 1978 but for a number of years returned to attend neurological teaching rounds several times annually. The latter years of his retirement were marred somewhat by ill-health, but he retained his keen sense of humour and his interest in many activities and he continued to enjoy reading, music and sporting events on television.

We extend our sympathy to his widow, Anthea and to his children, Christopher and Angela (both Guy's doctors) and Caroline (a Guy's physiotherapist).

JCH

Dr Michael McCall

Dr Michael McCall died on 2 December following a car accident. He was born in Blackheath and entered Guy's Hospital in the middle 1930s. He took an active part in sport, being a regular member of the hospital rugby 'A' team, captaining the swimming team, excelling at water polo and was awarded a half blue.

He joined the RNVR in 1939 and qualified in 1940. He spent some time in the early days of the war at Guy's, having been appointed an OPO followed by other appointments at Joyce Green Hospital before being called up in 1941. Initially, he served on destroyers in the Atlantic, but later transferred to the Fleet Air Arm. It was here that he met his wife to be, Becky Ball, whom he married in 1942 resulting in nigh on fifty years of very happy married life.

After the war he continued serving in the RNVR, eventually retiring in the rank of Lieutenant Commander, and was awarded the VRD. He then decided that public health was his m)tier, and after taking the DPH was appointed Assistant Medical Officer to the Kent County Council. His next appointment was Medical Officer of Health at Crewkerne and District, and subsequently Community Physician for the West Somerset Health Authority. During the previous appointment, he was involved in the control of a very extensive outbreak of Salmonella, 620 cases in children in Chard and District. A paper he published on this outbreak was received with much acclaim.

His pleasures in life were many, particularly the joy that he had in the company of his children and grandchildren. The other was his garden. Thirty years ago he and Becky bought a derelict small holding and had a house built, and transformed the ground into a beautiful wooded garden. The acme of their success was to have received a request from the English Camellia Society asking them if they could view it. He also organised a squash team which he took around Somerset playing clubs and schools. This activity had to be abandoned following bilateral hip replacements. A very severe neck injury three years ago precluded him from being so active in the garden so he transferred his energy to his greenhouse.

He was a very regular church attender and it is incongruous that the car accident should have occurred on his way to mass

at South Peterton Church where later his funeral service was conducted. He was a great believer in keeping in touch with friends old and new, and those of us who had the pleasure of staying at Field House knew that his friendship, hospitality and kindness knew no bounds. All of his contemporaries will remember him with great affection and our sympathies and those of his countless friends are extended to Becky, Simon—a Guy's graduate in Canada, his daughter Francis and his six grandchildren.

Requiescat in pacem.

WBDM

The ruffian on the stair

Nurses have a great deal to do with death. They care for the dying. They perform the last offices for the dead. They break bad news, both of prospective death to the patient and his relatives, and retrospective death to the bereaved. Above all they strain to avoid the death of those whom they nurse.

Perhaps it is the latter aspect of nurses' work in the community, but especially in the hospital, that has contributed to the negative image approach we have of death today. At one time, hospitals were feared as a place where the probability of emerging in a 'quick' state was poor; now, hospitals are more like pit-stops for racing cars, preparing the injured and ill to go on and on.

Death has exchanged places with sex, by comparison with the Victorian epoch, as the modern taboo subject. Death is, both literally and metaphorically, shrouded in mystery today; we seek to sustain life at all costs—life expectancy rates grab the headlines—death of a patient often represents a nursing and medical failure.

Possibly there is a wind of change in the air. The Victoria and Albert Museum in Kensington has mounted an exhibition on the theme 'The Art of Death'; (free entry until 22 March). In its explanatory leaflet a chord is struck: 'Death today is rarely discussed openly, euphemisms are employed to avoid even the use of the word, and brief, sometimes reclusive, rituals mark the moment of death. Yet our ancestors' response to death was quite different from our own. They openly recognized death as a universal human experience, surrounding themselves with objects and artifacts to remind themselves of their own mortality'.

I would only question this statement on one main point. An ex-Guy's employee wrote that we do not experience our own

death: 'Death is not an event of life. Death is not lived through'. This description was given by Wittgenstein who, observant members of staff will note from the brass plate, worked in our pharmacy from 1942-43. (I have often wondered which wise staff member was responsible for installing this plaque, and also which less wise person was responsible for its semi-concealment by a grey cabinet. Or am I wrong, is it not the staff, but a legacy of John Major's visit at the topping out ceremony?)

Furthermore, with the decline of religion, secular funerals are becoming more popular. I have acted as officiant at such a ceremony, which mourners who think this life is all we will ever know, described as 'dignified and beautiful'.

My own belief in an after-life vanished many years ago, when after seeing a funeral, I performed, as children are wont to do, a ceremony at which my teddy bear was buried in the garden. When I returned the following morning he had been removed from under his tomb of a cornflake packet. I looked at the spot in amazement, thinking. 'Jesus was here', and stared into the sky. My faith was soon shattered when I found teddy tucked at the back of a wardrobe. I burnt him!

Nowadays, fewer folk believe in the literal transmigration of the soul at death; this is probably why we find it harder to accept our departure.

Nevertheless, we must face death, and it is cruel of nurses to deny it, as sometimes happens when asked crucial questions by sufferers. Death is the one certain 'fact of life'!

I was pleased to note the V & A exhibition was well attended on the day of my visit. Parents with quite young children were explaining to them the details of 'A Dead Child', coffins, biers, palls, catafalques and mourning rings. Although, I am a little uncertain over the response from one youngster in a buggy: 'Where's the dinosaurs?'. I was once described in these pages as a dinosaur, by someone wishing to pay me a lack of compliment. I felt rather pleased. How can one criticize species which, I learned from a recently published book, The Fate of Dinosaurs by Anthony Milne (Prism Press), allegedly survived over twice the length of time than their supposed extinction 65 million years ago would have us believe? In the aeons of time, man's existence is a paltry affair, and one should not get too steamed up when the candle of life flickers out after four-score, or so, years.

And what of the part of this mortal span which frequently becomes unbearable through pain and suffering? The law opposes euthanasia. But many nurses know they have participated in the early release of patients recognized to be beyond medical salvation. Nurses may be frightened that in our cost conscious NHS these days, lives may be terminated because they are no longer economically viable. This already happens where ethical decisions are made on flimsy grounds when considering some expensive life prolonging therapies. The need for a properly regulated, legal, voluntary euthanasia scheme should be given potent consideration before the name of Hitler is invoked.

Of course, death is a cause of great sadness to the bereaved. The death of a young person always is devastating. Modern medicine may claim to have diminished childhood deaths, but the banishment of infectious diseases owes more to hygiene. However it is only a decade since the first AIDS diagnosis was

made; the ominous trend has continued bringing death to many in the flower of their youth.

The torch down-turned with the flame extinguished—a symbol of death—feature notably at the gate of the famous nearby Nunhead Cemetery. Our own, and others', mortality is worth a thought; I would recommend any nurse to visit the V & A and read in the brochure: 'How can we know when death will strike? The only certainty is that he will visit us'. Oh, and my title? These are lines from a poet crippled from boyhood:

Madam Life's a piece in bloom
Death goes dogging everywhere:
She's the tenant of the room,
He's the ruffian on the stair.
(W E Henley 1849-1903)

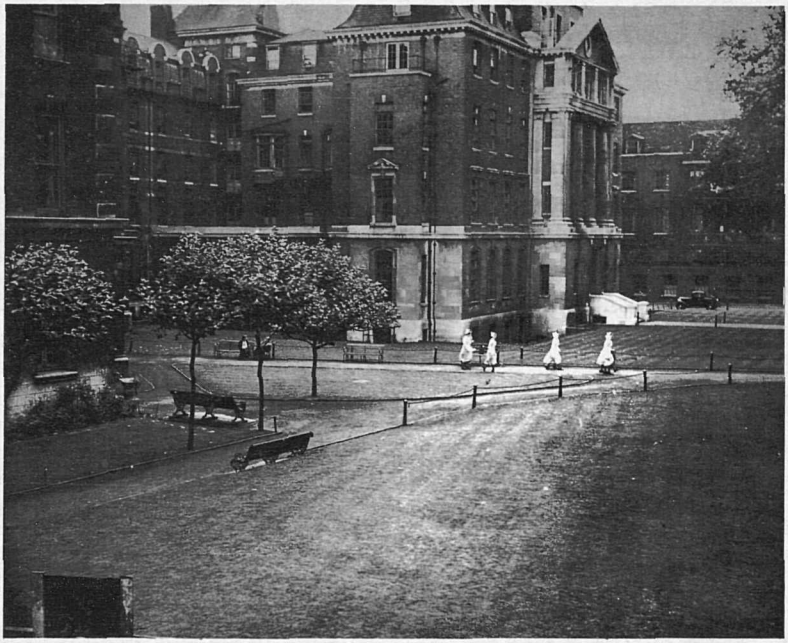
Denis Cobell

NHS—year two

March is the final month of the financial year; the final month of the first year of the new NHS; the final month of the steady state contracts. For some, this year has been the same as many before—attending to the needs of the patients as best we can. For others it has been full of management and administrative headaches. Headaches of keeping within ever diminishing budgets; of being charged for services for which one has never been given a budget; of maintaining a post-graduate education programme in order to ensure that services will continue to be of the finest quality; of working on business plans in preparation for 1992-93s activity-based contracts and on service agreements to ensure that as many holes as possible are plugged.

The physiotherapy business plans are underway. Deadlines have been regularly moved as financial information is not clarified. As this piece is being written, we are still in a state of waiting. Hopefully all will be revealed in time, before the agreements have to be finalised, formalised and put into action on 1 April 1992.

Quality assurance of standard setting, monitoring and feedback have been with us now for over 20 years. Back in 1981 senior members of our profession worked with the King's Fund and drew up documentation for auditing the standards in physiotherapy departments regarding environment, education, communication, records and service. What foresight they had. Many of us talked about it and paid lip service to it, now we are deeply involved. Some standards have been agreed and set in each clinical area and small



Physiotherapy—seventy years at Shepherd's House

audits have been done on record keeping so that a total programme is set in order to audit every aspect of the service at least once every year. Fortunately some of our environment is being improved for us. Our waiting area has been promised a coat of paint and not only has every window of Shepherd's House been stripped, repaired and painted but now the whole house is undergoing sandblasting.

During the time of noisy and dirty activity the students are not in the polythene enclosed classrooms, trying to learn against the noise of the blasting apparatus, which is joined in the middle of the afternoon by the bird scarer. It would be an impossible task. Fortunately they are on their penultimate clinical placements.

By the time the Gazette is in print I hope that the house to which William Shepherd gave his name will be unwrapped from its parcel of scaffold and polythene and will reveal a worthy neighbour for the medical school. Shepherd's House was opened on 15 July 1921 by HRH The Duke of York. The Massage and Remedial Exercise Department had been slowly growing since 1888 and a school was formally set up in July 1914 and housed partly in a temporary building next to the old clinical ward (which stood on the site of the new Shepherd's House and was previously the lunatic ward). When Shepherd's

House was opened the nurses were on the two upper floors and the Department of Radiotherapy and the Department of Massage, Remedial Exercises and Electrical and Light Treatment were placed on the two lower floors. Seventy years in the same place is some tradition to be matched and one of which we are very proud.

Diana Innocenti

Rugby Club

The Storming Fusiliers v Old Caterhamians III
Nov 23. Lost 0-20.

Firstly I would like to thank Mrs Goldring, Mrs Ferns, Mrs Elson, Mrs Pryke, Mrs Taylor, Mrs Gall, Mrs Dyer, Mrs Hughes, Mrs Prendergast and Mrs Walstoneholme, for allowing their sons to play.

My thanks also to Simon Levin for turning up to Boland House, however somehow we managed to loose him between there and platform 4 of London Bridge Station, but 10 points for effort Simon.

I would like to thank James Dawson for at least wanting to play for Guy's fifths, unfortunately his mother would not allow him. I would like to assure Mrs Dawson that the sort of game we play is not a complete facsimile of what she may have recently seen on television. Thank you also to Mike Goodwin for his efforts to get there, he was unable however to find the place, which might be one of the easiest to find.

Due to a fatal accident at Norwood Junction, we took the scenic route via Clapham Junction and Waterloo. So I really should thank British Rail or Network South East or whatever they call themselves for providing us with 2 hours of interesting rail travel.

We eventually got to the ground very late, in fact dusk was in sight when we started. It was a fairly uneventful match, *'we lost'*, but nevertheless an enjoyable one. I shocked everybody by managing to catch the ball from kick-off cleanly, but we all soon recovered from the scarcely believable experience.

Finally I would like to thank the caterers. When I went to get my tea, after 2 hours on four trains all I got was one burnt sausage. Maybe there is a moral there, or maybe not.

Harry Evans

Hospitals' Cup Football

UMDS 1st XI v St Bartholomew's 1st XI Semi-final

Once again we had reached another UH cup semi-final; was it going to be third time lucky? Previous kamikasi style defeats were probably on the minds of many in the preceding weeks, but we had a strong, mature and ceative side, eager to prove the pundits wrong. The venue was Motspur Park (the Mecca of London college soccer), the air was crisp but the pitch was rather disappointing and not conducive to the UMDS style at all!

The first half was a jumble of nervous, apprehensive and disjointed passes and after 15 minutes our game plane was decimated when 'H' was carried off. We had to reorganize and bring Brendon 'Hendricks' O'Reilly on at left back. Occasionally the midfield stalwarts of Buck and Crisp would threaten to dominate (usually verbally in the case of Mr Crisp). All in all it seemed as though the UMDS engine needed some new spark plugs - as did the opposition—to refurbish a very lack-lustre 45 minutes. The second half began with a crescendo of predictable phrases from Bill, our cliché-maker, and an aura of expectation. The ball swept out to the right, Bill's penetration and cross, a definite infringement inside their penalty box, confirmed by the grim reaper placing his scythe across his chest. Penalty awarded.

Mr McDonogh, super striker, one-nil. Our tails were up with victory in sight and we dominated the game for the next 20 minutes. the mystical Kite, flamboyant Crisp and the daunting Betts started to perform; the ball ran for us and we were in command. The back four started to push up, then disaster! We were left wanting on the right and Barts were level. Nervousness reared its ugly head and nobody wanted to make a mistake as the thought of extra time demoralised everyone. 90 minutes completed with another 30 to go. The occasional attack would send an anticipatory wave through our ranks, but to no avail as with 15 minutes to go the doomsday clock was counting down to the shoot out. Penalties were never our strong point but it need not have bothered us for out of the mêlée of their defence, breaking their offside push, was McDonogh. A succinct first touch followed but only one more and their onion bag was full. The buzz had only just subsided when Barts ran out of time.

Roll on Charing Cross!

Kite

Hospitals' Cup Rugby

The Rugby United Hospitals Cup kicked off with its now legendary hectic start. In the 2nd round Roy led his gallant band to a noble victory and Ole, our bagpiper, led the supporters to a great victory off the field. It has to be said that Guy's naked enthusiasm for the game of rugby was most noticeable at half time during what was rather a one-sided match. The person at St Georges who took defeat the hardest was the barman who by all accounts was a very nasty piece of work.

In the semi-final the boot was on the other foot with Guy's being well beaten by a strong St Mary's side, however by the

end of the match everything was a blur for most people and Cockburns were the outright victors. The coach driver was a really nice chap too—wasn't he?

Picking out individualls at these events is always difficult but Mr Haematemesis deserves special mention for a job well done—I hope the ensuing gastroscopy went alright!

Guy's have, however, reached the final of the UH soccer cup on March 1 and it is rumoured that bag woman will have her last outing of the year on that day.

Steve Pryke

. . . and fought for every ball . . .
(**Photo**: Ole Vielemeyer)

New doctors

The follwing students qualified MB BS (London) in December 1991:

Amin, Miss C L
Amos, H T
Arasu, Miss A
Banerjee, S
Barwell, J R
Bhoomkar, A A
Bowden, Miss J E
Caine, D J
Caller, Miss H A
Chadwick, Miss F D
Cohen, A R
Davies, N H
Drury, R E F
Egerton, D R
Huggins, Miss E
Lau Lao Ling, Miss B
Mitchell, P D V
Oatham, Miss C E
Penge, Miss D J
Qidwai, Miss A
Shirvani, R
Yousef, Z R

The following student qualified MB BChir (Cantab), in December 1991:

Rutter, H R

The following student qualified LRCP, MRCS in October 1991:

Barwell, JR

New dentists

The following students qualified BDS (London) in December 1991:

Angelescu, Miss S
Bates, Miss C S
Beck, Miss R L
Beecroft, Miss C L
Bharwani, Miss M
Boden, J M
Borhan, Miss K
Butt, Miss Z
Ching, L Y-K
Chok, Y F
Clapp, A J
Colebourne, Miss J S L
Copson, P D
Davenport, N J
Dixon, E J A
Dooley, M J
Doran, J G
Dufu, Miss A A
Friedmann, M E
Griffiths, Miss H S
Harris, G R
Johson, Miss N C L
Kelley, S S
Kennedy, P J
Khanna, S
Leach, Miss H A
Macey-Dare, Miss L V
McCullagh, J
McLaughin, M D
Malik, Miss F
Meakin, J
Murray, T B
Naterwalla, N
Nguyen, Miss N A N
Omell, N S E
Owen, Miss S E
Page, J R
Parmar, A
Pirbhai, M M
Poughadiri, M
Prater, B J
Rankin, Miss C E
Ray, Miss P J
Riddell, Miss E S
Safiullah, S
Sarin, Miss S
Seal, G J
Sergides, Miss I
Shah, M A
Shirodaria, Miss S
Smith, G I
Spedding, Miss C A
Swistak, Miss B E
Tam, J O W
Waddington, Miss J C
Willings, M V
Worth, J C
Wright, Mrs A B
Zia, P A

Change of address

Drs Ann and Charles CLEMETSON
Five Oaks Farm
RR1 Box 338
North Pownal
Maine
USA 04069

Dental practice

Ex-Guy's graduate retiring from two man expense sharing dental practice in Bideford, Devon. Leasehold property and low overheads. Little capital required for good will and equipment. Please contact continuing partner Mr T Gilmore, Tel (0237) 474229.

Deaths

BIGBY, Hilda Marian (née New) died on 4 January 1992 in Southampton—wife of Murray Bigby (Guy's 1923-31). Marian trained at Guy's and was sister on Naaman Ward; (Guy's 1926-32).

HOUSE, Donald Victor, aged 91, died peacefully on 2 January after a short illness. He was past President of Institute of Chartered Accountants, Governor of Guy's Hospital, past President of Herts Golf Union. A dearly loved father and grandfather. The funeral was held on 13 January at West Herts Crematorium.

MYERS, Philip Bryan, LDS, RCS, of 27 Corfe Way, Broadstone, Dorset died on 27 January 1992.

Birth

CLEMETSON—3 October 1991 to Ann (née Lawson), and Charles, a second daughter, Elizabeth Jane.

Classifieds and Announcements

The *Gazette* is pleased to publish classified advertisements. These are charged at the rate of 10 pence per word—money with order please. It is helpful if you can include a contact telephone number in case of any queries.

Announcements of births, deaths and changes of address will be published free of charge.

Please ensure that these items reach the *Gazette* office four weeks prior to publication.

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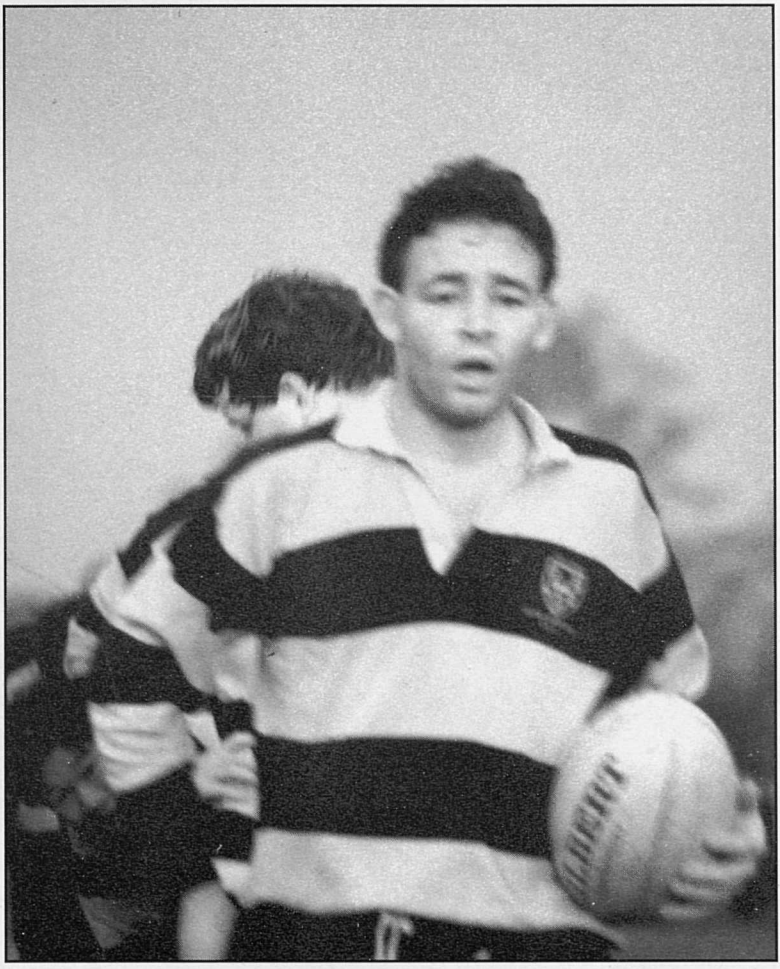
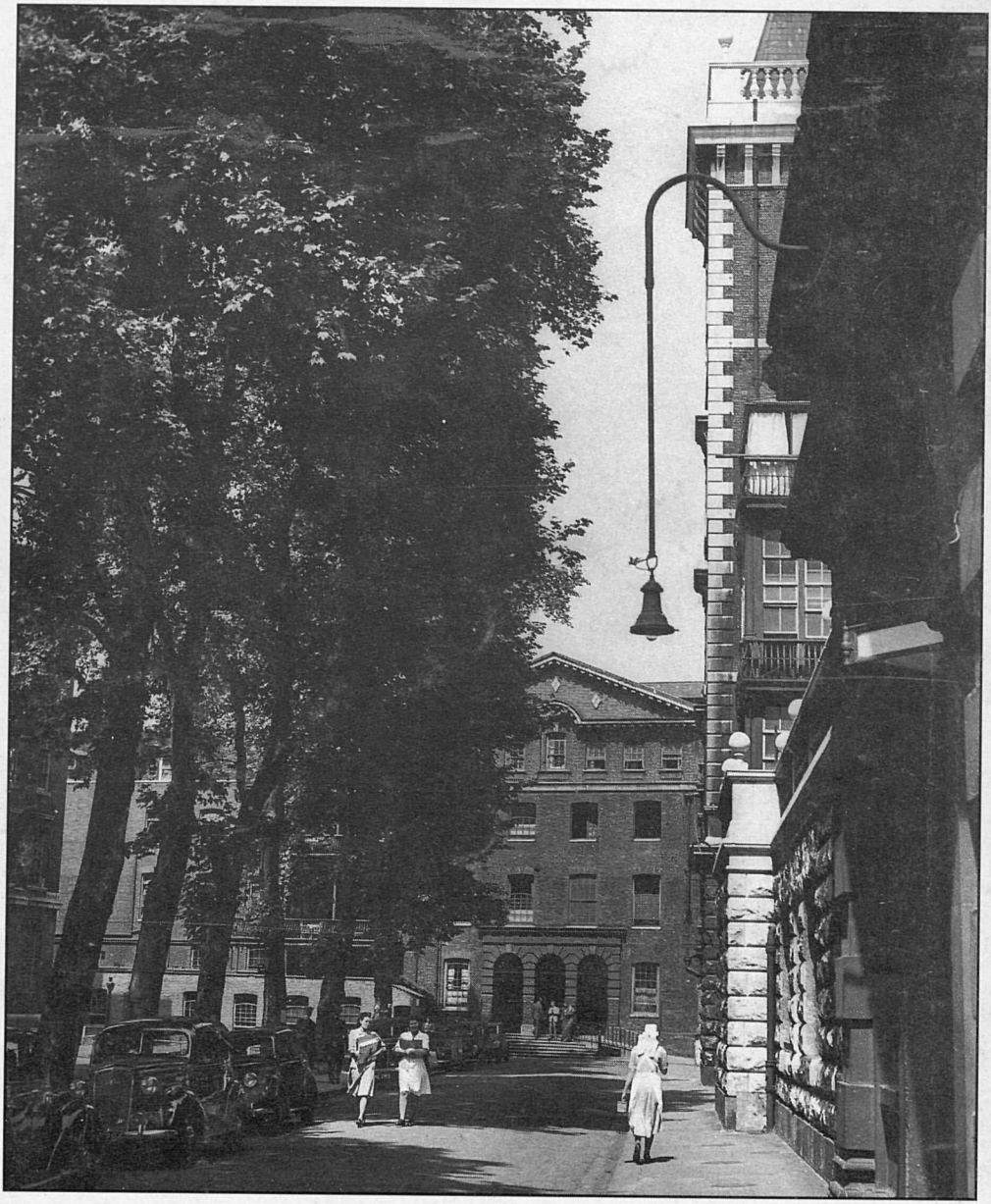


. . . but alas we lost.
(**Photo**: Ole Vielemeyer)



GUY'S HOSPITAL GAZETTE
April 1992

THE WILLS LIBRARY
- 6 MAY 1992
GUY'S HOSPITAL MEDICAL SCHOOL

- Marketing research—changes in funding
- A BSc—a student's guide
- UH Football victory

UH Football—our winning team

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Passim

This month's mailbag contains a whole host of complaints from everything ranging from teaching to the environment (well our immediate environment at any rate).

It is a feature of institutions as large as this that it is impossible to satisfy all people at all times—I think everybody accepts that. This does not justify change for change's sake, nor does it excuse disregarding the opinions of those whom it affects. It all boils down to communication, or rather a lack of it. The more involved people are in the process of change, the greater their perceived locus of control, and the less unhappy they are likely to feel about it.

Certainly, concerning the changes to the Park, although the end result may well be preferable, it may have been wiser to have a procedure such as that employed by local authorities whereby proposed plans can be examined by those who will be affected. Comments can then be made as to their individual preferences. There are, however, drawbacks with schemes such as this, one being that the options available are often very similar, with only superficial differences; but it still imparts a sense of participation in the decision making process.

Dissatisfaction with aspects of the courses being run is a somewhat different problem. It is certainly disheartening if students see the same shortcomings of a course being repeated year after year. The situation is compounded in a field such as medicine by a reluctance for most students to voice concerns for fear of possible retribution in terms of sign-ups and the like. It seems that some students have even refused to write anything for an alternative BSc guide, just in case it is viewed unfavourably. In all honesty, is there any other undergraduate discipline where students would be so reluctant to participate in something as innocuous as this? A similar inhibition has resulted in junior doctors having to wait so long before seeing any changes in their contracts and working conditions. The departments concerned can help by having a system allowing confidential assessments of the course by students, and then acting on the findings. In all fairness, some do, and in particular, the Block I Pathology was improved almost beyond recognition in response to student suggestions. On behalf of those of us that have benefitted, let me thank those who were instrumental in bringing about these changes, and wish them well with the Path finals.

THE WILLS LIBRARY
MAY 92
GUY'S HOSPITAL MEDICAL SCHOOL

Belated presentation ceremony

Dear Sir,
While many *Gazette* readers will be aware of the plans of the University of London for a presentation ceremony for those who took their degrees in the war years, others may not be so aware.

The Princess Royal will officiate, the date is 23 June, at the Royal Festival Hall at 2 pm, and all information can be obtained from the office of the Vice-Chancellor at Senate House. Those of us who intend to be there will greatly look forward to renewing old friendships, some of which will be of well over half a century's standing!

Yours faithfully,

GEORGE CROSS
Christchurch
Dorset

SMEC plans

Dear Sir,
I am writing to you as the newly elected chairman of the Student Medical Education Committee. I would like to assure your readers of my intentions to continue to represent the views of students in the aim of furthering medical education.

However, there will be some changes to SMEC's organisation. There will be an emphasis on the following points:

- Student representatives will be chosen by compulsory elections each year (even if it means I am not re-elected).
- We will strive to poll students on any major issues we approach the medical school with.
- We will also be more readily available to students for consultation.
- We intend to be answerable to students.
- We will look closely at ways in which SMEC's organisation can help the Clubs Union in other welfare matters.

I hope to be able to publish a guide for prospective BSc students shortly which will outline reasons for not doing a BSc as well as highlighting the benefits.

With the introduction of the new curriculum and so many students not really knowing what it entails, a guide explaining the changes in an 'easy to read' form is being prepared.

SMEC is often thought of as an organisation that does not achieve anything and that may well have been the case a long time ago but things have changed! As the student passes through the medical course he or she may be involved in assessing their education at the time and any improvements get passed on to the year below. What the student does not realise are the changes that have already been made in the year that they have just entered. Admittedly, this has been a fault of SMEC in not publicising changes that have been made. To counter this we hope to produce a review detailing changes we have made over the past few years in circulation soon.

Finally I would like to introduce you to your representatives: 1st year: Nicholas Prophet, Vanessa Thornton; 2nd year: Helen Binns; BSc year: Edward Mckintosh; 1st/2nd year clinical: Saikat Banerjee, John Chinegwundoh, Shubhinder Shergill; final year/house officers: Tom Brett, Charles Phillips; secretary: Shahid Khan.

Please note that the 2nd/3rd year clinical elections are in April.

If you would like to contact any of the representatives or wish to discuss any matters relevant to SMEC you may contact me on (081) 692 2043.

Yours faithfully,

OMAR RAHIM
SMEC Chairman
Boland House

New ID cards

Dear Sir,

As you may have noticed while waiting to enter the bar on a Tuesday or Friday night, the issue of security and admission to the bar is an important one. The campus committee have thought long and hard, and have come up with a solution we hope will mean an easier, simpler entrance to the bar. There are at present three types of student membership, each with their own specific identity card. medical and dental students are full members and are identified by their blue UMDS card. They are the only people who can admit one guest.

Qualified doctors and dentists are life members, and have similar rights to full members. At present most life members are struggling to maintain their flea-bitten cardboard identity cards with sellotape, plastic and luck. To combat this, we are introducing a robust, credit-card style card, sponsored by the MDU in the next month.

Student nurses, radiographers and physiotherapists are affiliate members of the Students' Union. Affiliate members cannot sign in guests to the bar. We are trying to re-negotiate block subscription with the various schools, but individual students may always obtain identity cards from Mike Fendick in the Accounts Office. We have produced a new range of cards which we hope will alleviate the difficulties of old and expired cards. We aim to introduce these cards to all affiliate members before Rag Week.

This should mean that everyone can enjoy the facilities of Boland House, which I am told are numerous and exciting.

Yours faithfully,

EDWARD SHARPLES
Vice-President
Guy's Campus

Galaxy blues

Dear Sir,

If your readers are not being sent up I have to say that I was saddened to see that a new sports club at Guy's is recruiting gay and lesbian members.

In the thirties I am sure the Dean (TBJ) would have had an appropriate answer for any aspiring student who, in his CV, indicated that his game of choice was sodomy. Even in these days I believe this dangerous contact sport should not be unduly encouraged by the authorities. I don't know whether a Blue or Half-blue would be an appropriate award for, how shall I put it, outstanding members of the club.

Lesbianism is rather a mystery to me, but I do hope the Clubs Union is not asked to invest in a great deal of new equipment.

I have always believed that the public had the view that many medical students enjoyed a reputation for strenuous heterosexual activity, but forgave this if

they were more restrained when qualified. How they would react to an organised homosexual cult I do not know.

In my day, on the sports field, jealous opponents referred to us as 'the buggers from Guy's'. One would not be so happy if this were not said in jest. Homosexuality may or may not be desirable within the Anglican priesthood, but I trust that Galaxy will not become the flavour of the month within the healing professions at Guy's.

Yours faithfully,

W T M HALE
Plymouth
PL9 7EE

Improve the big Guy's teaching about the little guys

Dear Sir,

I am currently coming to the end of my paediatric firm at Guy's. I feel far from confident in the examination, diagnosis, and care of children. This is mainly due to the absence of both teaching and enthusiasm in the paediatric establishment here. The patients at Guy's are far too specialised for undergraduate medical students and we ought to spend more time learning general paediatrics at a district general hospital. The ward rounds, when they happen, have 11 students, which of course is not at all intimidating for young children. The most worrying thing is that these complaints have been voiced by many paediatrics students in the past, but without any apparent response from the department.

It is with regret that I am forced to write this letter, but I feel that strong words are necessary to draw attention to the plight of students doing paediatrics at Guy's, and to persuade the lethargic, inactive paediatric department to bring excellence in teaching back into a department renowned for its excellence in practice.

Yours faithfully,

V P D'OFF
Boland House

Accommodation office

Dear Sir,

The problems with trying to get accommodation at St Thomas's are that:

- You have to face a whole multitude of differing responses on each visit to the accommodation office.
- One of the 'officers', although usually courteous and polite, makes many promises and yet has absolutely no power, and is therefore wholly ineffective.
- The other officer in question is totally condescending to most students, and makes it quite apparent that she is doing us a big favour just by talking to us.
- There are no rules to adhere to for gaining accommodation, hence it's probably easier to sell Gazza to Lazio than it is to get an honest answer about the chances of getting accommodation.
- Accommodation at UMDS is limited, and most of us are indeed grateful that there is at least some; however there is an insane amount of difficulty presented when trying to arrange it.

To their credit, the officers run the hostels well; however they should make more of an effort to try and help students find accommodation both at UMDS hostels and just as importantly outside the hostel system. Maybe being nice would help.

Yours faithfully,

FRUSTRATED
No fixed abode

What's happening to the Park

Dear Sir,

For many years I have considered it a privilege to work in the medical school building. The Victorian values of workmanship, such as the woodwork, marble, wall tiles, floors of mosaic and parquet, and the brass fittings (which are so lovingly cleaned by the ladies) are enjoyed and appreciated. Regretfully, all this is disappearing. The floors are covered now with an easier to clean surface, the tiles are stripped from the walls, and the brass door furniture is going in the aid of security locks. Lack of maintenance is also taking its toll. At the top of the steps to the entrance, the cement needs replacing underneath the Yorkshire stone, before it crumbles.

The Park is also suffering. Year after year we have received much pleasure from the spring blossom outside the building. Suddenly, just as it was becoming green, the flower bed was cleared, the shrubs and other plants decapitated or uprooted. We are told that the Park is to be landscaped and new paths laid. It is sincerely hoped that we will not lose the Yorkshire flags (it is reported that in London whole pavements are stolen overnight, the value of this stone is so great). They are a joy to walk on and it is great fun jumping the puddles when it rains!

May a plea be made for us to retain also the cast iron (said to be Napoleonic cannon) posts, many of which have been dug up at the present time. It would be dreadful to have more of those pseudo- Victorian type posts such as the newly installed sign-posts. The Victorians gave us much of which to be proud, please may we be allowed to keep and preserve the medical school and it's surrounding area.

Yours faithfully,

S WILLIAMS
Department of Biochemistry
UMDS

Burns v Shakespeare

Dear Sir,

My sincere congratulations to Professor Ian McColl for his splendid translation of one of the greatest narrative poems ever written (*Gazette*—February 1992) thereby bringing it to a wider and hopefully appreciative audience. It has obviously been a labour of love for him.

I am reminded of the story of a Scotsman who, in the last century was asked for his opinion of Shakespeare. I too have provided a 'translation' of sorts:

'Shakespeare—Well, Well! No doubt a very great poet. I wouldn't just venture to say that our Rabbie (ie Robert Burns) could have written Hamlet, but then there's always two ways of putting a thing. Do you really think that Shakespeare could have written Tam O'-

Shanter? Deil the fears o' him! (The Devil he could!).'

Yours faithfully,

DR HUGH M BAIRD
Greenhead of Troquhain Castle
Douglas
DG7 3QJ

Plasma losing favour

Dear Sir,

In my first ode to the *Gazette* my purpose in writing is two fold, to prove that people from Cornwall can write and to express some dissent from among the ranks. The music at the Hops and Inflams seems to be getting more and more obscure and seems to cater for the taste of the DJ and very few others, this and the fact that requests are turned down flat for 'popular' and 'old favourites' is meaning that attendances and Hops and Inflams is falling and people end up leaving early, surely this must be affecting both bar and sports clubs door takings. To cater for all tastes I accept is not possible, but to cater for such a small minority is really quite unacceptable. From discussing the matter with my peers, I am now of the belief that a majority of students require a change and would pass a vote of no confidence in those running Plasma, and that if this situation persists something further must be done.

Yours faithfully,

W DYKE
Floor 24
Guy's Tower

Matron—should be more than a title

Dear Sir,

As an ex-trainee of Guy's and subsequently a Sister Tutor with Sisters Hilda Geaton, Florence 'Flo' Taylor and Janet James, I was delighted to read in the February *Gazette* that Miss Wilma MacPherson was reinstating the title of Matron—but then was saddened to read that it did not denote any organisational changes. What a pity—because one had hoped that one would never again witness the disgraceful manner in which the last Deputy Director of Nursing was required to relinquish her post. I wonder how Miss E E P MacManus CBE and the real matrons who succeeded her would cope with or tolerate the present organisation?

Yours faithfully,

FAITH RIGBY (née HOOD)
MBE STD SRN SCM
Nurses League

Dirty washing?

Dear Sir,

Hurrying, bleary-eyed from the medical school library I espied a large new-looking truck adorned with our inspiring trust motif and the words 'Guy's and Lewisham Trust Linen Service'. Beneath the message was a telephone number. 'Why?' I wondered. Are we hoping that one of the burgeoning number of NHS managers, or one of their wives perhaps, will be driving their courtesy car, notice the advert and then, using their courtesy car-phone, make an enquiry. Is the Trust

now taking in other people's dirty washing to make ends meet?

In a market economy, I am sure that it is an excellent idea, especially as we already spend so much time washing our own dirty linen in public.

Yours faithfully,

NOLAN HUNTER
Boland House

"Quote-Unquote"

An Obs and Gynae consultant during a tutorial:

'You need a licence to even drive, but sex is kind of easy once you get the hang of it. You think people should be allowed to have kids without needing a licence?'

(There was a time when you did need a licence—it was called marriage—Ed)

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Bomb at London Bridge

An IRA bomb exploded in London Bridge Station on 28 February. The bomb went off in the men's lavatory on platform 4 at 8.26am—one of the busiest times of the day at the station. Traffic and transport in London was thrown into chaos following mass evacuation at all British Rail and London Underground stations.

Eye witnesses described scenes of panic with dozens of people sprawled across the platform. Twenty-eight people were injured, four of them seriously, and received treatment at Guy's casualty, already well-honed by the Marchioness and Cannon Street station disasters. Guy's A & E was put on full alert within 10 minutes of the blast, following radio broadcasts appealing for doctors and nurses to give assistance.

Major-General Norman Kirby in charge of casualty operations at Guy's said that the commuters were lucky to have escaped with relatively minor injuries given the usual nature of bomb explosions. The potential for damage in the rush hour was very great indeed.

New ideas for A & E 'advice line'

An innovative casualty department at the Royal Preston has started an advice line. Patients ring in to see if it is necessary for them to come in, and they are given an idea of how long they may have to wait. The casualty consultant described the phone service as a 'civilized way of practicing A & E'.

Female condom launched

Femidom, the female condom, has been released in Europe. It began selling in shops in the first week of February and will be launched in the UK this Summer.

This effective barrier provides protection against pregnancies and sexually transmitted diseases, and has no effect on the body according to the manufacturers, Chartex.

Clinical trials have involved 1700 couples in over 15 countries so far.

King's Fund report

Results from a two year study, known as the London Initiative, conducted by the independent King's Fund charity show that Londoners get a poor deal on health care. This is in spite of the NHS spending up to twice as much in the capital, compared with other areas.

Although Londoners are generally healthier than people elsewhere in the country, suffering less lung cancer, cervical cancer and circulatory disease, they have a higher incidence of breast cancer, suicide and alcohol related disease.

They also often have problems gaining treatment for ordinary non-specialist illnesses. This is blamed on the development of highly technical specialities for rare conditions at the expense of more mundane local services.

Consultants are also accused of taking an increasing number of private patients at the expense of NHS patients. The growth of private health care has also reduced teaching availability for medical student training.

Good food at Guy's

Guy's Hospital has officially launched a new patient meal and menu service on 2 March. This is the culmination of efforts over the past year by Gary McKenna of the Catering Services Department, Karen Sorensen of the Dietetics Department and Caroline Waldegrave and Claudia Roden of the Guild of Food Writers.

The aim has been very much to move away from the institutional food, so often typical of hospitals, and provide a more varied range of higher quality meals for all inpatients. The menu will aim to meet the needs of special diets and those from different religious and ethnic backgrounds.

A booklet containing recipies from the menu has been produced by the Friends of Guy's. Patients are encouraged to take this booklet with them on discharge.

GPs' own Information Technology school

The UK's first computer training centre exclusively for GPs was opened in SE London last month. It is designed to teach GPs how to use computers and choose appropriate information technology. The centre is run by Lambeth, Southwark and Lewisham family health authorities.

Bar closure

The Guy's bar has recently been closed following an incident where damage was done to the ceiling.

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Marketing Research

Research at UMDS moves into the 1990s

Government funding of higher education is set to change from 1 August with the arrival of the Further and Higher Education Funding Act, 1992. This act includes a restructuring of government research funding and heralds an era of increasing competition amongst the research establishments. This competition fits with the market-oriented philosophy of the present government, but how is research at UMDS attempting to adapt to this cold, cruel, competitive climate?

The Act abolishes the distinction between universities and polytechnics, the polytechnics receiving university status. The University Funding Council (UFC) and Polytechnics Funding Council (PFC) will be amalgamated to form the Higher Education Funding Council (HEFC). The HEFC will allocate funds among all the establishments. It will work on the the principle of the 'level playing field', allocating funds on the basis of an institution's expertise in research, rather than its historical status. Under the present system, the UFC funding allocation is determined in part by an assessment of the quality of an institution's research—known as the 'JR' or Judgemental Rating. As far as UMDS is concerned, Dr Hywell Thomas, the Pre-clinical Dean, confirmed that the JR for the majority of departments ranged from average to top or near top marks. Under the new act, research funding will be increasingly determined by the quality of research that an institution supports. Dr Thomas stressed that the UMDS JR score needs to be improved—by upgrading the quality of research work, and by attracting high-quality scientists. However, the JR score is an average of the work of several departments, some of which do better work than others. This works two ways—while the better departments 'pull up' the rest, the poorer departments 'pull down' the better. The possibility of improving overall JR scores by 'dropping' these poorer groups was left unstated. Dr Thomas was also concerned that competition between UMDS and other medical schools could increase. For example, UMDS is not a 'greenfield' site, unlike St George's Hospital Medical School, and that affects its ability to attract top-class research.

Another effect of the Further and Higher Education Act is to stress the demarcation between funding for teaching and funding for research. This philosophy has been criticized in some quarters, for who can say where

teaching stops and research starts? This may be apparently quite clear at medical school (how should we view the research element of intercalated BSc projects?) but it is definately not so clear on more conventional degree courses. To clarify the distinction between funds for teaching and funds for research, the Act removes the 'student numbers element' which currently contributes to research funding and removes any provisions for 'cross-subsidy' between the teaching and research allocations. The overall effect of this is to make the full costs of research in universities apparent by revealing the previously hidden costs of administration, libraries, etc. These costs are currently included in the total UFC allocation, but in the future they will be borne by purchasers of university research, for example, the research councils. To cope with these increased research costs (which are estimated to increase costs by about 40%) about £150m was transfered from the UFC to the Science Vote (the amount of money that the research councils such as the Medical Research Council—MRC—have to spend). This was, in the words of a spokesperson from the Department of Education and Science, 'to enable the research councils to pay for the research that they are getting from the university'. Unfortunately, the move to reveal the true costs of funding university-based research was widely misinterpreted as marking the end of 'dual-support', the arrangement under which the government provides the costs of the basic infrastructure of university research to allow the universities to pursue specific external funding from charities, industry etc.

In February of this year, the *Observer* carried the story 'Charities "will quit" university research'. The gist of it was that the changes to university research funding would force universities to pass on the true costs of research (the average increase of 40%) to charities supporting university-based research. The reaction of the charities to this idea was predictable. Professor Gordon McVie, Scientific Director of the Cancer Research Campaign (CRC), went on the record saying 'We are not going to pay more to do the same research... We will spend our money elsewhere in our institutes'. However, the spokesperson from the Department of Education and Science confirmed that the role of the new HEFC will be the same as that of the UFC and the PFC. It will provide the 'on-costs' to support charitably funded research at universities—in other words, the dual-support system would remain. But anxiety among the charities remains. A spokesperson from the CRC noted that explicit confirmation of the maintenance of dual-support was only forthcoming after the publication of the *Observer* article, furthermore, the explicit guarantees only extend until August 1993, 'no decisions have been made, we're still considering the situation' say the CRC. A spokesperson from the Association of Medical Research Charities (AMRC) said that the provision for charities was less than

explicit when the changes were initially aired. They are currently satisfied with the provisions and will continue to monitor the situation.

It seems that concerns about dual-support remain, although they are directed less towards the actual existence of dual-support than towards the level of the provisions. The majority of the total £16.5m gained by UMDS in 1991 to support research came from charitable sources. Much smaller amounts came from the government and from the Research Councils. UMDS, in common with many medical schools, is vulnerable to changes in the pattern of charitable research funding. This is a potential problem. If the government element of dual-support starts to fail UMDS will find it harder to attract this important charitable element. Although UMDS is currently successful in attracting charitable funds (a total of £9.2m in new grants for 1991 were obtained from charities) the high turnover of these grants indicates a need for future caution—they could fail to be renewed. There is another problem, in the words of Dr Thomas 'charitable funding won't pay for the overheads'. In the new competitive environment for research funding, it has become increasingly important for UMDS to gain more consistent, longer-term funding—such as MRC Programme Grants. (Unlike the three-year MRC Project Grants which support an individual scientist and some equipment purchases, the Programme Grants are for five years and can support whole groups and their equipment needs). Dr Thomas: 'UMDS has been very successful in this area recently, with MRC Programme Grants being awarded to support research in the departments of Immunology, Anatomy, Histopathology and Genetics, to groups led by, for example, Professors Lehner, Lumsden and Walsh'. More such grants will be needed in the future.

In general terms, the outlook for research at UMDS is favourable, for example, the schools were able to increase their total research budget by 17% last year. However, the high turnover of grants shows a lack of consistent funding, and a vulnerability to changes in funding policies—whether by the government, research councils or the research charities. The immediate target for research at UMDS is to increase the quality of its work and its facilities. This will help UMDS to obtain more consistent funding, and will enable UMDS to attract and support more research. Towards these ends UMDS is refurbishing many of its facilities and is fortunate in having the help of the Guy's and St Thomas's Trustees in this task. But long term problems remain. The cost of equipment is increasing at a faster rate than government support has allowed for. There is a general lack of space at laboratories at UMDS, which causes difficulties in attracting new research and in expanding existing research. Salaries for university research are failing to keep up with those available in industry or in the United States—the 'brain-drain' has not gone away! And for

the source of these problems? Dr Thomas: 'Taken as a whole, there is no doubt that government provision for research is declining'. It is almost as if the government views research funding as a rather unwelcome historical burden, rather than an asset both to medicine and to the country as a whole.

Laurence Reed

Guy's Hospital — 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number is available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital — 250 Years, Guy's Gazette, Boland House, London SE1 9RT.

Veneral Disease and Dermatology in 1969

Dermatologists—the crème de la crème of physicians?

Back in 1988 Lucien Freud had an exhibition of his work at The Hayward Gallery and I thought it would be no end of a treat for my younger son, William—then age 14—to see it. When we came to it, I had not expected to see quite so much pink paint and such a vivid exploration of the female nude, and a few male ones too. Undaunted, I marched the lad round the exhibition and he managed to keep a straight face throughout. As I emerged from the Gallery I was—shall we say—somewhat hot under the collar and it occurred to me that he might be interested to visit Guy's so that he could see the hospital where his father had trained. Whereas I knew little or nothing about painting, I reasoned, I did know a lot about Guy's and it would be rather fun to pay the old place a visit.

As I drove through dear old SE1, I regaled him with the fact that it was possible to go from one part of the hospital to another without ever appearing above ground. I thought this diversion would make up for what he'd just seen at The Hayward Gallery, you see. I got a place in that NCP Car Park round the back and we sallied forth across the Park towards the medical school where I knew we could make a start on this adventure. I had always thought it rather neat that we could get from one place to another—when it was raining—without a raincoat.

What happened next put me in mind of Michael Horden's butler who is getting a bit senile and loses his way in the vast baronial building Michael Palin has visited. The film was 'The Missionary'. Similarly afflicted, we wandered up and down, round and about, popping up in various parts of the hospital I no longer recognised whilst my increasingly perplexed son tagged along. After twenty minutes or so, I drew stumps on the whole enterprise and made for The Tower where I explained there was a very good lift ride to be had right to the top of the building; thereafter affording an excellent view of London. When we reached the top, I successfully identified London Bridge Station but little else.

Skins and VD was a bit like that: lots of pink skin, lots of diversions and the promise of a fine view at the end but always provided that one knew what one was looking at. In those days we used books to learn our venereal diseases; the two important ones being syphilis and gonorrhoea. Whilst we saw the latter as being just a dose of the clap, the former rejoiced in a euphemism viz lues—pronounced Lewes (the one near Brighton) and consultants like Dr Willy Mann called it luetic disease. There is a Suffragan Bishop of Lewes by the way, and once I met a clergyman—one Jeremy Saville—who had decided that if ever he was consecrated he'd like to be Bishop of Sodor and Man and then he'd be able to sign himself 'Jeremy Sod'. However, I digress. Once we started talking in terms of luetic disease a consultant could talk in rather less than a hushed whisper about all its fascinating manifestations. When grandfather asked for the hand of my grandmother from his father-in-law-to-be, he was instantly asked if he had syphilis. The year was 1901 and for the rest of her life, Mater—as she was called—was constantly reminded of the dire line of questioning he had had to endure to gain her hand prior to their inevitable marriage and birth of five sons. Tuberculosis had its own euphemism; that being 'phthisis' and Residents' Plays were forever peppered with allusions to apocryphal housemen who had met erstwhile nurses only the previous evening with widespread phthisis.

Treponema pallidum had been discovered in 1905 by a Prussian zoologist called Fritz Schaudinn and its only application in my all-too-brief venereal encounters was to see it painted on a fourteen foot Enterprise Class sailing boat which belonged to Ed Townsend (now pulmonary surgeon at Harefield Hospital) and Adrian Caro (now a GP in East Anglia). The term 'syphilis' came from a poem which told of a shepherd, Syphilus, who had been struck down by the disease for failing to worship Apollo. It was published in Venice in 150 by Dr Girolamo Frascatoro, a physician of that era. Venice must be quite a place. When my elder son, Charles, returned from a holiday there with his school, he presented me with a set of shark's jaws. The streets were permanently flooded and they all ate ice-cream by the bucketful. In the bad old days, a night with Venus meant a lifetime with Mercury; another heavy-handed medical joke. Nor did I ever see 'Hutchinson's teeth'; nor have I attended 'Stainer's Crucifixion' although I understand it is very painful. I don't remember Dr Grimble although he must have been about, but then I hardly ever visited the Annex—as it was called then. I remember studying the faces of the charge-nurses there and wondering if they really looked anything like pox-doctors' clerks. Venereal disease seemed like a cheerful sort of subject but the advent of AIDS changed all that and now there is an ever-widening range of diseases that may be contracted by the enthusiastic amateur. More's the pity.

In 1969, we got our lectures from a bald-headed man with spectacles and a series of slides which made a chap think twice about fooling about.

There are one or two things that need to be known when it comes to the study of skins and venereal disease. Firstly, the difference between a cream and an ointment, and secondly, the difference between the circumcised and the uncircumcised. I was nineteen when I discovered the latter in the Dissecting Room one hot and sultry summer's afternoon—and twenty-one when I discovered the former. My upbringing had somehow slipped a cog in the 'facts-of-life' Dept and I was never informed of them until the annual lecture from a weary priest at Epsom College. By that time the wires had got quite badly crossed because assumptions had been made as to my state of knowledge which were not in fact so. One was either a Cavalier or a Roundhead—and that was that. Consequently, some quite important points in the New Testament had lost their significance, but I need not entertain you with them here.

I can't think who it was who told me the difference between a cream and an ointment—I'd like to think it was Charlie Wells—but it did make a big contribution with regard to the subsequent management of skin disease. In the late sixties, there were two doctors who seemed to have been at Guy's for many many years. Dr Louis Forman had been a consultant at Guy's since 1932 and Dr E J Moynihan had certainly been there since the war. I was on Dr Moynihan's firm and most of the teaching took place in outpatients. The firm sat round the periphery of the consulting room like inmates of an old peoples' home whilst Dr Moynihan sat behind his desk dwarfed by the white coat he wore over his three-piece suit—the patients managed to keep most of their clothes on with Dr Moynihan; not so with Dr Forman. Just an offending portion of skin was enough to set Dr Moynihan off on a train of thought, which, though quite brilliant, tended to go over my head. His prescriptions were liberally splattered with Latin phrases and Greek signs and most of the discussions concerned what was happening at a cellular level to the afflicted skin in question. Dr Forman's outpatients resembled a nudists' colony and there must have been quite a few goosepimples on view. He always insisted on seeing the whole skin surface of the body and though I felt sorry for the patients I have tended towards his view these days.

Charlie Wells made dermatology interesting and was one of the new school of doctors who was prepared to treat medical students like fellow human beings. There are not a few dermatologists who owe their careers to the way Dr Wells fired their interest in the subject. The senior registrar was Tony Bowyer and he was most entertaining with his stories; one of which I still remember, concerning the lady with eczema of the nipples. She had proved to

be a baffling case and had had everyone scratching their heads as to the cause of her affliction. There had been an endless array of tests and she had even been part of a case conference, but the cause had escaped definition. Then one day she came to Dermatology OPD with her husband and it was noted that he had a magnificent moustache. Someone put two and two together and it became apparent that she was allergic to the hair dye he had used to colour his moustache. I was reminded of the story because I have just dealt with an identical case.

Wednesday afternoons were interesting if the student had it in mind to learn more about oral pathology. Professor Lehner, Dr Forman, and Charlie Wells tended to get together and roam the wards of Hunt's House asking for anyone with mouth ulcers. Having located a suitably afflicted oral cavity, there would be a huddle about the patient's bed whilst the said ulcers were examined by everyone present and then followed a learned discussion which had all the elements of a lobster quadrille about it. My impression was that having made as many attempts at an explanation as possible the cure was invariably the same viz a mouthwash composed of oxytetracycline and nystatin. These rounds gave me a chance to have a closer look at Dr Forman who always fascinated and entertained with his vast store of knowledge. He was known as 'Lolly' Forman and I never discovered why. There was talk that he was very rich and maybe that was something to do with the nickname. Perhaps there is someone out there who can tell me why he was called 'Lolly Forman'?

Meeting doctors socially is always pleasant, and a while back I had the pleasure of meeting Dr McDonald—known to us all as 'Mac'. Once we had negotiated the primary social sallies, we found that we had a common interest in 'off-the-road' vehicles. Whilst I could boast a Shogun, I believe Mac informed me he had a Dihatsu and two Suzukis. I wonder what kind of car Freud drove?

We all know that series of aphorisms that states that: The physician knows everything and does nothing: the surgeon knows nothing and does everything: the dermatologist knows nothing and does nothing: and the pathologist knows everything a day too late. I have always felt that dermatology creams off the best minds around. Genito-urinary medicine is no longer a Cinderella amongst the specialities and for the researcher who cracks the codes which will eliminate AIDS there is at least a Fellowship of the Royal Society, a knighthood, and an OM too. In 1969 I really had little idea of homosexuality and my mother didn't know it existed. VD lectures tended to talk of what happened if you got it but not of how it got to be there in the first place and a few hints and tips about the practice of homosexuality would have been helpful. As for myself, I shall be leaving the country when they make it compulsory. There is a fashion

about at the moment for the psychologists to furnish us with the details—and though it doesn't seem terribly nice in its way, it's helpful to be brought up to date on something that must have been going on for thousands of years.

I leave you with the story of the Spanish 'au pair' who came into my office one morning. 'I feel lousy.' she said. Looking at her, I could only see a beautiful Spanish woman with raven hair—and then I looked again—and she was!

J H Pitt-Payne

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A BSc—Why? Which One? How to Apply

The definitive guide

With part IIs safely finished, and that memorable 6th term approaching, many of the current second year students will be considering the option of an intercalated BSc. This article is intended as a user guide for any potential applicant; which questions to ask, of whom and especially, why? I remember a career's adviser at school informing me of the real meaning of the abbreviations BSc, MSc and PhD—BullS*!t, More of the Same and Piled higher and Deeper, of course! So you still want to do a BSc—not a bad decision, it seems, considering that about 50% of students take the opportunity each year.

Why?

Medicine and now dentistry are some of the longest undergraduate courses as it is at five years, so some would think it undesirable in the extreme to extend them by another year, especially since it delays the long awaited patient contact which led most people into medicine or dentistry. However, there are many reasons that are given for doing the course. It certainly means that you get the benefit of another long summer holiday—though I think it would be frowned upon if you approached a department with this as the main reason for wanting to do their BSc. A mercenary attitude is sometimes applied when it comes to a BSc. Some may consider it only as a potential CV filler, or perhaps as a means to that elusive first publication. It is not surprising that in a field as competitive as medicine, such attitudes can prevail. Though these can be benefits of doing a BSc, they should not be viewed as the objective. A publication is by no means guaranteed, no matter what impression previous students or supervisors may give, and not producing a paper at the end can result in disappointment, if that was the only motivation for the course.

A BSc can provide an excellent opportunity to get hands on experience of the real world of research. This can range from literature searches, study design and practical work, statistical evaluation, writing a project and presenting it to other members of the department. It must be said however, that the

most important piece of research that can be done for a BSc is that which you do before you start. You have to consider the choice of course very carefully indeed. This involves acquiring some raw data in terms of the factual information regarding the course; this can be obtained from the BSc booklet and from the course co-ordinators. In addition, you need to consider the information in context, and the previous students can offer some help in this respect. Be careful when asking the current year's students about the course. There is likely to be a systematic error giving rise to negatively biased responses due mainly to the impending final exams and project deadlines. Don't lose hope though, hundreds of their predecessors have survived and lived to tell the tale, and as with all stressful episodes, there is a strange satisfaction in the recounting of hardships overcome.

Research is important

So what are the points to consider when choosing a BSc? Well the subject is quite an important one. There is always the option of doing anatomy, biochemistry, physiology or pharmacology if you want the security of subjects you are already familiar with. For others, I am sure that the thought of persisting with these subjects for another year will be just too much. There are plenty of others to choose from though. Some will have been introduced in the BMS course, such as genetics and sociology while others such as history of medicine offer relatively uncharted waters to explore. There is however more to a BSc course than the subject title. The actual course needs to be considered in more detail. Different subjects place varying emphasis on the amount of teaching in the form of course units. This is important to consider, since a BSc may be seen as an opportunity to read around a subject rather than sit through yet more lectures. The scope of the teaching is also an important factor when it comes to deciding the course to do. It may be all well and good being very interested in the child development parts of the BMS psychology, only to find that it isn't being offered this year in the BSc, or conversely, the radiological sciences lectures (or at least the one you went to) might have seemed very tedious, but they may not be very representative of the subjects covered in the BSc. It is sometimes possible to choose the particular course units—although limited numbers for any one may make the department reconsider running the course.

Obviously, where there is teaching, or even where there isn't, there are usually exams. I think most students will find it essential to investigate the number, frequency, and importance of these exams; they can, for example, seriously impede plans of Christmas skiing trips and the like. In some courses,

immunology being one such, assessed exams are held on different topics once a fortnight.

The project

So, what about the project? There is more variety regarding this aspect of the BSc course than any other. Some don't even require you to do a project! Others have several mini-projects to be completed throughout the year, and there are always those courses with one main project to be submitted. Even within a particular course, there can be great differences in the types of projects on offer. Some will involve patient (or volunteer) contact, while in others you can be content with playing with a computer or test-tubes. It really depends on your inclination which one you choose.

There are some general rules to bear in mind when it comes to projects. With computers you can generally stop when you like, and then start off where you left off—provided the computers haven't crashed! On the other hand, running gels in biochemistry, and incubation periods when culturing cells can provide ample opportunity throughout the day for honing up on the snooker skills, or for getting the latest references, depending on whichever you find more interesting. With a single project, consider the maxim: 'the first 90% of the project takes 90% of the time, and the last 10% takes another 90%.' This can present clinically with insomnia and an aggressive possessiveness towards the Apple Macs in the Academic Computer Unit. Seriously though, the above is absolutely true, and there are more tricks of the trade that can be picked up from previous students.

There are, however, other factors to consider about the projects. Some need to be chosen in the sixth term, and researched over the summer, while others are arranged at a more leisurely pace once the course has actually got under way. A project comes bundled with a supervisor, and it's as well to make sure that your supervisor isn't just about to spend the next six months on an exchange programme to the States. Again, it is useful to ensure compatibility between you the student and your supervisor—and no, I don't mean that you have to have the same star sign! Some will insist on a much greater component of independent working, which may not suit those who would prefer to have regular consultation and 'hand-holding' sessions. Don't forget also that being a member of a research department is usually going to mean presenting your work to your colleagues in anything ranging from an informal seminar to a formal presentation. As people always tend to say about pain, it's all character building stuff.

With this year's applicants being loyal to UMDS through and through, the question of where the course will take place is less of an issue. Some are

predominantly Guy's based, like anatomy, while others like immunology are at St Thomas's. There is also the factor that some courses will involve attending lectures, or using the facilities at other colleges or institutions. It is also possible to apply to do an intercalated BSc at another college, but this will need to be arranged with them and the medical school. One of the most popular choices is to do the UCL psychology course.

Applying

Now you've got something more to consider than a vague notion of wanting to do a BSc, what next? There is the whole rigmarole of applying to the various departments that you've chosen, and waiting to see whether they want to choose you. You are allowed to state a first and second preference, and then it's out of your hands. Departments have their own policies when it comes to selecting students. Some use the rank in the year, while others are more interested in the mark obtained in their subject. Places might be allocated to those choosing the course as first choice, in preference to those who have placed it as a second choice, despite the fact that they might have a higher mark.

Marks are also important when it comes to the question of funding. Students are ranked on the basis of the Part IIA marks, and the money is allocated in line with the local authority allocations that would have been received, until it runs out. It is therefore very difficult to predict how many students will receive money from the medical school, but suffice it to say that last year about 80% received their entitlement. It's at times like these that you wish you'd applied to Oxford or Cambridge—because the BSc is an integral part of their course, and so local authorities agree to provide funds. Most local authorities don't provide money for the intercalated year, since they say it is a second degree. There are some other trust funds and companies that may sometimes give sponsorship, and also the possibility of applying for access funds from the medical school.

All in all, it can be a very satisfactory way to spend a year, which can both be enjoyed and benefitted from by both medical, and now, dental students. Alternatively, there's always clinical, which can be just as enjoyable, and you still have the opportunity to reconsider the decision and intercalate a BSc after one year of clinical.

HM and FFH

The UMDS Student Counselling Service

A confidential ear

'Counselling Service? What Counselling Service?' Even though the Student Counselling Service has been in existence for well over a year, we find that this is still the response of some UMDS students, particularly from the dental school. The counsellors, Paul Pavli and Diana Bass, are presently based on the first floor of Riddell House, at St Thomas's Hospital. This can seem quite remote and the journey between Guy's and St Thomas's can be difficult at times. With this in mind it might be a good idea to let students based at Guy's know a bit more about the service.

The UMDS Counselling service was set up by the medical and dental schools in recognition that students need different kinds of help with the often rewarding, but always demanding and frequently difficult task of training in medicine and dentistry. Help and advice for students is available from many sources, through tutors and advisers, Registry staff, the Occupational Health department, and many other people involved in the welfare of students. The counselling service is an additional resource, which is confidential and is not part of the academic assessment process. The counsellors recognise that asking for help, particularly for medical and dental students, can feel like a sign of weakness. Sally May, in an article about the counselling service in the Autumn 1991 issue of the *St Thomas's Hospital Gazette* discusses the 'acceptable weakness' in all of us. It is now widely recognised that counselling is an acceptable and constructive way of dealing with a whole range of issues. Indeed we would go further and argue that asking for help in times of difficulty is a positive sign of health and an important first step towards increased understanding and development of the self, invaluable as a health professional.

The issue of confidentiality when students use the service is extremely important and the counsellors are aware that this point is fundamental in allowing students to use the service freely, and with complete confidence.

What are the problems and concerns that people bring to counselling? Very often it is a feeling that somehow things have gone or are going wrong and

there is some confusion about why this is happening. This may be concerning and affecting study, family, friends or other relationships. The counsellor can help to clarify what is happening and think together with the student about what is needed to resolve the difficulties.

Finally, there is the possibility that a suitable room will soon become available at Guy's to provide a comprehensive service for students who have difficulty in coming to Riddell House. The counsellors can be contacted on extension 2410 at St Thomas's and there is also a booking system for personal callers on the first floor of Riddell House. The counsellors offer other services as well as individual counselling. Look out for posters about an Exam Workshop early in May and the student counselling group starting soon. The reception room at Riddell House also has information available on a wide range of issues.

Paul Pavli and Diana Bass

Student counsellors Paul Pavli and Diana Bass

Clinical specialities

Oxford Handbook of Clinical Specialities. Collier, Longmore and Harvey. Published by Oxford University Press. Price £12.95

The Oxford handbooks are both well known and popular, and the publication of the third edition of this member of the series, only four years after the first says much about its success. It aims to be a 'friend in the pocket' to GP trainees, junior doctors and clinical students in the subjects of obstetrics and gynaecology, paediatrics, psychiatry, ophthalmology, dermatology, ENT, orthopaedics, trauma and anaesthetics.

The page-a-subject layout facilitates instant reference to the salient points of many conditions, whilst being of a size to be easily concealed in a white coat pocket. This is useful not only because of the value of looking up diseases as you see them, but also because it provides a logical framework to later elaborate on with other more detailed books.

Differences between this and previous editions include: a new, brief chapter on anaesthetics; more diagrams (including cartoons, and an illustrated technique on how to release 'zipped penises'!); the addition of many new topics in all chapters; plus numerous updates of previously included topics.

Whilst offering a condensed source of information, the authors have avoided unexplained, incomprehensible lists. There are interesting topics mentioned that are only normally considered in tomes on the subject (for example—a brief overview on helicopter transport), also including detailed advice on social and psychological aspects and how to approach sensitive topics (for example—a page on talking to parents about a child's mortal illness).

From a medical student's point of view, this book is incredibly useful, but it is by no means—and does not aim to be—a replacement for the conventional texts, and should be considered to be complementary to them. When compared to the price of most undergraduate books, at £12.95 the Oxford Handbook of Clinical Specialities is a definite bargain.

H Martin
4th year medical student

Paediatrics

Manual of Pediatric Physical Diagnosis. Lewis A Barnes. 6th Edition Published by Mosby Year Books. Price £22.00

This is an American book, in its 6th edition, the first dating back to 1957, and it remains a single author publication. It is clear that large sections of the book date from the 1950s, both in medical content and style.

There is a good introduction, emphasising that there is no 'routine' examination in paediatrics, and that opportunism and versatility are necessary to get the most from your assessment. A discussion of 'normality' versus 'average' is useful, and he emphasises the importance of noting the trend in observations of aspects of development and growth. There are some helpful tips on gaining the cooperation of young patients. Unfortunately, there was little else to recommend.

My criticisms are of the overall style of the book in general, and numerous specific points in particular. There are only 57 illustrations in over 230 pages, and none at all in an entire chapter on

examination of the newborn. This is a serious shortcoming in any book aimed at teaching physical diagnosis. There is no attempt to list causes of physical signs by how common they are; there is almost no use of tables and boxes containing important facts. The text seems randomly organised and very overinclusive. Thus, histidinaemia appears before psychological disturbance as a cause of delayed speech, and cerebral tumour before oesophageal reflux as a cause of vomiting in infants. Urinary tract infection is not mentioned as a cause of vomiting, but imperforate hymen is.

There are numerous anachronistic statements that I feel should have been revised after 6 editions. 'Listening for the typical sounds of peritonitis may be the only way of detecting pneumococcal peritonitis in nephrosis...' and 'Paresis may occur with congenital heart disease' are examples. 'A third fontanelle is a sign of an infant at risk' is not helpful. Absence (petit mal) seizures are described merely as 'brain disturbances causing loss of consciousness...accompanied by abnormal electrical brain discharges.' The description of Weber's tuning fork test for hearing disturbance is incorrect. Whilst rare diseases are mentioned in place of common ones throughout the text, HIV is noted only once.

One of my most severe criticisms of this book is that some of the teaching may be dangerous. Examination of the throat with a spatula to inspect the epiglottis in croup or possible epiglottitis is contraindicated, and yet is described in detail by the author. He also explains the technique of direct laryngoscopy, mentioning that the child 'should have an empty stomach to obviate aspiration of vomitus during manipulation.' In describing the difference between seizures and syncope, he writes 'Seizures resulting from vagal-mediated cardiac arrest can be produced by 10 seconds of pressure on the eyeballs.' Are we meant to attempt this?

This book cannot be recommended.

Dr C Reed
Senior Registrar in Paediatrics

The Harriet Lane Handbook. 12th edition, Edited by Mary Grigorian Green. Published by Mosby Year Books 1991. Price £13.50

The Harriet Lane Handbook is the distillation of the knowledge of the paediatric senior house staff of the Johns Hopkins Hospital in Baltimore, and is intended as an easily portable source of the information necessary in the practice of hospital paediatrics. This edition is arranged in five sections: practical procedures, diagnostic tests, formulary, therapeutic data and reference data, and covers the ground in exhaustive fashion. There are many segments which attempt to explain some of the underlying principles of investigations or practice; radiology is a good example of this. However, on occasions, the efforts to be all-encompassing are perhaps a little misplaced. For example, while a list of possible substances leading to different urine colours is of use, I wonder how many house staff in general paediatrics would have use for a chart for normal palpebral fissure length?

One is struck by the differences between UK and American practice in some areas, and by the difference in drugs available for common conditions such as asthma, and by the dependence on different units for nearly all common laboratory investigations. This, and the widespread use of abbreviations of

American practice without a glossary, make it a difficult book into which to dip without some idea of what you expect to find, but as a compact but exhaustive source of paediatric information, there is no comparable single volume on the market.

Neil Thomas
Paediatric Registrar

Quick review

Surgical Secrets: Questions you will be asked. 2nd Edition by C M Abernathy and A H Harken. Published by Hanley and Belfus. Price £20.50

This book is an attempt to look at the whole spectrum of surgery together with intensive care, nutrition and fluids by a basis of questions and answers. It is written very much in the American style, full of substance with little in the way of padding. It is certainly not a book to sit down and read, and could not be looked upon to replace standard textbooks, as it is not a comprehensive cover of the field of surgery. It would, however, provide a break and an alternative from conventional textbooks and would be more appropriate to people sitting the new Fellowship exams, where the need for knowledge of intensive care, enteral nutrition and fluid balance is required.

Robert C Mason
Senior Lecturer and Consultant Surgeon

Modern trends in organ imaging

This was the Dental Society's second evening foray in to the invisible subject of radiology and its application and relevance to the field of dentistry. Yet another full house was irradiated with an overdose of particles of wisdom from Dr James McIvor, from the Charing Cross Hospital.

This lecture could have been regarded as the sequel to the presentation by Mr Whaites at the beginning of the year—'Seeing is believing' (December *Gazette*). Whilst Mr Whaites concentrated on the more clinical aspects of radiographic imaging and the encountered difficulties of interpretation, Dr McIvor narrated a differing perspective, discussing the relative flaws and merits of the variety of diagnostic imaging techniques available to the

modern-day practitioner, (usually via his local DGH).

Fortunately the audience was exposed to only the basic technological data relevant to the particular technique, whether it be conventional radiography (plus or minus the use of contrast media), ultrasound scanning, computerised tomography or the most up-to-date process of magnetic resonance imaging (MRI) and positron emission tomography (PET). Most of these recent advances rely on the principle of minimizing the exposure time to the patient, but thus suffer from two major drawbacks: one is the image gathering time and the other is the 'thickness' (ie depth of field) of the resultant image; tomograms are images of cross- sectional slices through the object and the thinner the slice, the greater the resolution of detail for the examiner.

Most of these recent advances rely on the principle of minimizing the exposure time to the patient ...

Dr McIvor took each technique in turn and proceeded to explain, both clearly and entertainingly, not only the theory but also its practical uses. Using colour transparencies, examples were shown of diagnosing parotid gland tumours using ultrasound imaging, ductal blockages of the parotid and submandibular glands using sialography, temporomandibular joint disorders using arthrograms and more recently MRI, and the fact that Dr McIvor has a brain, verified also by MRI!

At the end of the presentation, the audience was invited to question the speaker; the subject of radiovisiography was brought up and Mr Whaites, in his element explained the usefulness of this procedure, especially if one had over £10,000 spare!

'Would conventional radiography become obsolete in the next few years?' was a question asked by the Kodak representative present. Dr McIvor gave the answer which he wanted to hear—X-rays are here to stay as a useful diagnostic measure. Let us hope that the Dental School may be equipped with more space to allow students to be able to learn and use this valuable aid in dental care, in the future.

The Dental Society wishes to thank Kodak for their generous sponsorship and Dr McIvor for his time and effort in assembling his presentation.

Avijit Banerjee

Keeping infection under control

'Oh, Germs are Germs,
and Wounds are Wounds,
and never the twain shall meet'
with apologies to the author of the *'Ballad of East & West'*—Rudyard Kipling.

When Mrs Jenny East, formerly Senior Nurse, Control of Infection, left Guy's last year she took a post advising first wave trust hospitals—not this one—on how best to ensure insurance claims on grounds of safety and infection control were kept to a minimum.

Now she has been replaced since January by Mrs Marie West, who has come from the east, where she was Deputy Head of Nursing Services for the past three years at Dartford. At one point Mrs West was Nursing Officer, Control of Infection at Dartford, a post also previously occupied by Mrs East.

Anyway, enough of these longitudinal differences; suffice to say both Mrs East, and now Mrs West, seek to advise all staff, in a multi-disciplinary role, on how to keep a safe, infection free, environment at Guy's. Time was when there was no such post as infection control officer, all nurses were expected to avoid cross-infection and keep the wards clean and tidy. Indeed Florence Nightingale's dictum ran: 'It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm'. However, along came antibiotics, the demise of matron's power over the domestic scene, nurses stopped wearing sensible caps to enclose their hair, and, hey presto, we became burdened with iatrogenic in-house bacteria. Hence the need for folk like Marie West, our Senior Nurse, Control of Infection.

Marie trained at Charing Cross in the 1960s, where she gained experience in the cardiac and orthopaedic areas. She married in the 1970s and took time out to have her family. Later she worked at Dartford on a female surgical ward, following on as Senior Nurse for Surgery, before she became involved with and took a course on control of infection.

She is alerted to instances of infection either via the microbiology laboratory staff, or anxiety from ward staff. Although strictly advisory, her role in limiting infection risks does have a compulsory element; wards or departments may be closed in co-operation with colleagues and the medical control of infection office—erstwhile Cassandra of the medical tabloids.

Marie intends to see clinical standards observed. She recognizes that there are domestic and environmental problems at Guy's. The domestic staff strive within the limits of the numbers of employees engaged; the site suffers while building work is in progress, but this does not mean yellow bags containing potentially contagious material should lurk at dangerous points. The prospect of these bags breaking open is never far from our minds. Some staff still carelessly place hazardous objects such as used needles and blades in these bags, which endangers those who have to handle them for disposal.

Thus the improvement of general hygiene is high on Mrs West's list of priorities. On a typical day she intends to have two appointments or teaching sessions, but these are speedily cancelled if an infection incident intervenes.

Marie has a prime input to student

nurse training and is clinically involved—this is a large part of her job. She would like to see the 'vacutainer' closed system for phlebotomy adopted at Guy's, as it is in many hospitals. She will teach anyone how to wash their hands—and dry them—correctly! Those who trained in the dim and distant past, before the days of CSSD, will have been taught more precisely in the art of sterilizing instruments; but the days of nurses' *Aids to Tray & Trolley Setting* by Miss Houghton have vanished.

Nowadays, swapping kidneys, hearts and other organs bring about as much excitement as seeing a peasant change his boots in earlier centuries. Thus we have new standards, and if the Labour Party forms a government after the election later this year they promise that hospital cross-infection rates will be published. We can anticipate Mrs West pointing at a neon sign in front of Guy's, emphasizing that our rates are lower than St Thomas's!

Marie is professionally responsible to the Trust's Nursing Director for Guy's and mental illness areas. She intends to set up further in-house training courses for nursing staff. As she leaves London Bridge each day, she has her family and dogs to return to in Kent.

Denis Cobell

Guy's Hospital Massage Association

We are coming into the final lap of the history of the Guy's School of Physiotherapy and it seems appropriate to look back at some of this history in these last few months.

A meeting was held on 13 December 1917 to discuss the 'formation and name of an association to unite all massage students trained, in training and to be trained at Guy's Hospital'. It was decided to name the association 'Guy's Hospital Massage Association'.

It was decided that the entrance fee would be 2/6 and that there would be a yearly subscription of 2/6 to be paid each January. The first Annual General Meeting was held on 16 November 1918 in the Massage Department of the Hospital, and the report of that meeting is abridged as follows:

Guy's Hospital Massage Association

This first re-union, on 16 November 1918, from 2-6pm was attended by nearly 150 members.

The Report of the Association

The very satisfactory results in membership show the students' appreciation. Since the Massage School started, some 230 students have entered for training, many of whom are now working in Military Hospitals and Camps. Out of this number about 150 are enrolled as members, and the roll is steadily growing. The aim of the Association is to keep in touch, through the membership, with students who have passed through Guy's Hospital, and by having re-unions at fixed periods to afford them an opportunity of keeping in touch with one another, either directly or through the list of Members kept by the Honorary Secretary. This useful organization will be assisted materially if Members will make a point of notifying the Association of any change of address, even though temporary.

In furtherance of the objectives of the Association, a yearly reunion of past and present students is to be held, and an annual report containing a list of Members, details of appointments, and other interesting and personal matter will be sent to all Members.

Again at the request of old students, a badge has been designed, and after six months delay, it is now ready.

General Report of the Massage Department

During the year over 1,000 outpatients and 500 inpatients have been admitted for treatment, and the daily massage treatments given number 200-250 cases.

Installed in the lower Massage Department is a large 'whirlpool' in which some 60 patients a day have been treated with hot aerated water at 110 degrees Fahrenheit.

A second addition has been added to the Massage Department consisting of a room 'for the treatment of women', which leads off the big massage room, so now large sets of students work with more comfort.

The Students

The School has kept up its numbers to between fifty and sixty students throughout the year, and entries have been made for every examination held by the Incorporated Society of Trained Masseuses during that time.

Those students who obtained 'distinction in the SRE (Swedish Remedial Exercises) or massage examinations have been awarded the Raphael Medal for Massage. This medal was instituted in 1904 when Mr E G Raphael presented a sum of money to the Hospital for those showing excellence in the ISTM examinations.

War Distinctions

The following have been mentioned in dispatches, and are still working in Camps and Hospitals: Miss D Brooks, Miss A E Exham, and Miss Messenger.

The Electrical School

At a recent meeting of the Guy's Massage Association Committee it was decided that electrical students holding a massage certificate should be admitted as members of the Association.

The Electrical Department

The average daily treatments, which are of a very varied character, carried out in the department are about sixty. During the year additions to the apparatus have been made, one very useful piece of apparatus being an electric metronome, which will give a constant current by adjusting a switch.

The Radiography School

The need for assistants to radiographers seems to be establishing itself, and several students are at present holding important hospital appointments—some in the provinces, one in London. Where x-ray, light, electrical and massage departments are combined, as is often the case in the smaller hospitals, students holding a massage certificate are very useful in taking charge, under supervision, of

the X-ray work, light, massage and electricity treatments.

The association changed its name to the Guy's Hospital Massage and Actin-Therapeutic Association at the AGM of 1922, then to the Guy's Hospital Physiotherapy and Radiography Association in 1947. The present position of the two associations, the Guy's Hospital Physiotherapists Association and the Guy's Hospital Radiography Association was decided at the AGM of 1979. The first meeting of the Guy's Hospital Physiotherapists' Association was held on 28 October 1980.

Diana Innocenti

A message from your President

The summer term has arrived. It's now the time to get into the frenzy of Rag Week, enjoy the fun and games of the Summer Festival, mellow out on the banks of the River Thames during the bumps and survive the all night Summer Ball. These activities mixed in with working for those enjoyable exams makes a perfect summer term.

I'm sure that the 2nd MB blues (I don't think you're allowed to call them 2nd MB any more Gordon—Ed) of the autumn and spring terms have not been easily forgotten. What else did we achieve in those terms. Well the UMDS football team won the UH cup at Motspur Park—a full report is elsewhere in this issue. Even though the rugby and hockey teams did us proud, sadly they failed to lift their respective cups. However, the supporters on the sidelines were definitely victorious. What will the the Hospital Bumps bring us? There have been many tours and trips, including that most enjoyable one to our sister school in Lille.

The autumn term saw two brilliant productions by the theatre club; Arsenic and Old Lace and the Christmas Show. Of course there were the Halloween and Dental Balls which were not to be missed, and we also witnessed the birth of the UMDS ladies' rugby team.

I hope that the first years' have enjoyed themselves so far, and have taken advantage of all the other sports clubs and societies UMDS has to offer. Perhaps you're longing for another Freshers' Week? Rag Week has to be the answer!

In past years, thousands of pounds have been raised during the

Rag/Charities week as a result of students trooping into the City and elsewhere in search of those spare pennies. You'd be surprised how generous the public can be when you're dressed up in theatre gowns, armed with Rag Mags and stickers. So, get involved and support the second year's in the events they have organised.

The Summer Festival and Summer Ball have been timed to be at the beginning and end of the term respectively, so that they interfere as little as possible with the work and exams of students of all years.

I do hope you can find some time to enjoy the many things that will be going on. Take care and good luck.

Gordon Kooiman

Charities Week

This year Charities Week will commence on Friday 1 May, taking in the Bank Holiday weekend and running till the following Friday. Many readers will know that the fund-raising is now undertaken as a fully integrated effort at both the St Thomas's and Guy's campuses. We are supporting the following charities:

The Braxton-Hicks fund at Guy's—which has a variety of areas of activity relating to obstetric and neonatal care.

The Lane-Fox breath-taking fund at St Thomas's—a respiratory unit for special needs patients with respiratory paralysis.

St Christopher's Hospice in Sydenham—a centre which provides care for the terminally ill (leukaemia, AIDS sufferers etc).

Daytime activities will be held, which we hope will be of general interest to hospital staff. These are still in the planning stages at the time of writing, but we hope to hold among others: a jumble sale in the Park, an auction of original cartoons by 'Fleet Street' artists and a Sumo-wrestling Basho.

The evening activities will be publicised nearer the time—look out for posters. There will be a Rag Ball, probably held at an external venue—tickets are on sale now and are very good value!

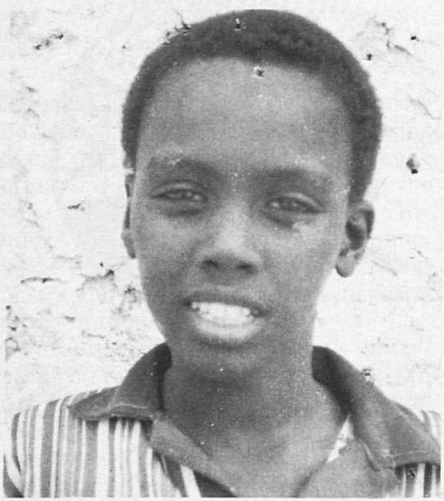
Anyone wishing to make a donation or some other contribution should contact our organisation through the Amalgamated Clubs' offices at either campus. All readers are welcome to attend any events which appeal. We look forward to seeing you.

Tom Brink
Co-ordinator, UMDS Rag Week

Orphan appeal

I would like to make your readers aware of the efforts of the UMDS Islamic Society in its Sponsor An Orphan Appeal. Following the launch of the campaign at last year's charity dinner evening, Moonlite, the society has started sponsoring an orphan, but would like to sponsor others in the future. We have started a donation scheme where any individual may part sponsor an orphan by paying from as little as £1 every month. Further information can be obtained by letter addressed to UMDS Islamic Society, Boland House or by telephone on (071) 733 9586. I am sure that there are many readers who, in true Guy's tradition, would like to help with this appeal.

Appeal Organiser
UMDS Islamic Society



Shukri Abdinoor—the first orphan being sponsored

The Summer Festival

This year to revive interest and to combat dropping attendance, the Summer Festival has been changed to a date earlier on in the summer term to avoid clashing with exams. The new date is Saturday 9 May, at Honour Oak Park, which follows on from Rag Week.

As usual there will be football and tennis tournaments, ladies' rugby, mixed netball, rounders and croquet. In addition, there will be fun races in the afternoon—egg and spoon, hurling the welly, three-legged and sack races, tug-of-war and naturally the obstacle course. A marquee will be set up selling real ales, plus a bouncing castle, coconut shys, candyfloss and food stalls. In the evening, after the presentation ceremony, we hope to have a barbeque with a live band and disco.

The Summer Festival is open to all students (past and present), doctors, Guy's staff and their families. If you would like to form a team for any of the sports events, please contact the Students' Union Office at Guy's (ext 5430).

See you all there.

Paul Brain
Social Secretary

Getting ready for Europe

Eurotalk, 8-10 May

Eurotalk is a French speaking weekend with an emphasis on medical terminology. It is not intended to be a comprehensive instruction in the use of another language, but more as a kick start to make people realise that learning another lan-

guage is not as difficult as you might think.

During the course of the weekend, you will be given revision of basic grammar, and then you will be given the opportunity to use it immediately in a conversation. After several such workshops where you will be aided by personal instruction, there will be role-playing sessions using the vocabulary that you have learnt, and you will wander around a mock hospital interpreting symptoms that patients complain of (in French), and you will have to ask directions to particular departments—in fact, all that you may do on elective in a French speaking country.

Food will be provided, and Saturday afternoon and evening will be spent at the Summer Festival. If you are interested in participating at the Eurotalk weekend, contact Fiona Arnold, Boland House, Guy's Campus, ext 5225.

EMSA

The European Medical Students Association, EMSA, has been in existence for just over a year. Its aims are to increase contact between students in Europe, as the barriers to mobility in the European Community are decreased during 1992. If you have any questions or ideas for EMSA then please contact your EMSA representatives: Fiona Arnold, Billy Kuteesa, Maxine Patel or Louise Ward.

The Dental Ball

The annual Dental Society Ball was held at its traditional venue—in the luxury of the Great Room of the Grosvenor House Hotel, on Saturday 22 February. It was a classy affair, with opulence and charisma abundant. The decorations of blue and gold balloons adorning both each table and the hall itself, merging together with the atmosphere of anticipation and excitement made the evening one to remember—a true highlight in the Dental Society's calender. The crowd arrived in droves, mingling and coalescing their way down into the Great Room, women comparing and complimenting each other's gowns.

The meal was served promptly, as wine flowed and bellies rumbled. The many wine waiters encircled the floor, continuously filling empty glasses. The food went down extremely well, although the vegetable strudel looked and tasted of a strange hybrid between a portion of rice and a slice of swiss roll (well, at least it wasn't vegetable lasagne again!). Dinner was accompanied by music from a jazz ensemble—far more appreciably received than the string quartets of previous years. Indeed an inpromptu version of 'Happy Birthday' was played to an unsuspecting guest, much to their surprise! The after-dinner speeches were brief, funny and much welcomed by the crowd (most of whom had by now lost touch with reality). Eventually, the band came on and the crowd rushed to the dance floor, led by the President and his Lady. To describe the band as the best seen at a dental ball, would be an understatement. Indeed the prospect of an evening without a DJ initially made many run for their nearest glass of red. However, after the first couple of numbers, it was obvious that the band were in a class of their own, mixing various numbers into thirty minute sessions liberally interspersed with 'mellow moments'; just right to keep the crowd cheering and dancing on. Many were captivated as the band changed outfits every

session, ultimately wearing red lycra shorts that nearly every woman noticed. It was not only the music of the band that held the crowd there, but also the amazingly choreographed routines. How on earth did they manage to play brass and dance around at the same time?

The plethora of balloons were soon removed, many now decorating various rooms across London. Mickey Mouse impersonators were to be seen everywhere, getting high on helium as well as alcohol. Eventually, the ball drew to a close, and the crowd made their way to the exit. Those that came for the first time vowed to return, and those that were veterans would also repeat the experience.

The dental ball is an annual institution, and although much has come to be expected of it time and time again, it lives up to its reputation of being, by far, the best ball of the year. However, this year the best just got better. Congratulations to all those involved with every aspect of its organization. More again next year, please!

SBP

'How on earth did they manage to play brass and dance around at the same time?'

UH football final

Guy's and St Thomas's v Charing Cross and Westminster 1 March. Won 2-0.

The big day had finally arrived—all the pre-match preparations had been made: kit washed, team selected (only just!), supporters' coach booked and plenty of celebratory liquid refreshment bought!

However, it was only 9 o'clock in the morning when the first catastrophe struck. Where was the Junior Cup that Guy's had won the previous year? Several phone calls later, the problem had been solved—unfortunately this year's winners might be a little upset when awarded a cup base and silver handle only!

The team had arranged the previous night at the pre-match meal to meet at 11 o'clock in the Spit, and the skipper was particularly pleased when the Andy Mead, Paul Kalra and Tim McDough trooped in on time, having been left in the restaurant just when the old vino was starting to flow; special congratulations go to Paul Wallder who decided that his bed was not as comfortable this weekend!

So as is becoming customary for the big games, the team made their way to Motspur Park by train, whilst the supporters were picked up by luxury coach. Having walked to the ground and inspected the pitch, the team was made complete by the arrival of John Goodlad, who had flown down from a wedding in Soctland that morning. The spirits were high in the changing room and there was a certain air of confidence and expectation. When all were ready, Henry Taylor led out his troops to a deafening 'Motspur' roar. As each of the Guy's and St Thomas's players was introduced to the crowd over the loudspeaker, it was clear which set of supporters were to dominate the game. When the opposition were being introduced, three stalwart Guy's supporters showed exactly what they thought of Charing Cross, much to the amusement of all from south east London. Introductions over, it was time to get down to business.

Charing Cross started frantically, having a lot of territorial advantage, but it was within the first ten minutes that Guy's and St Thomas's, especially the midfield quartet of 'Kitey' Hawksworth, Tim Buck, Matt Crisp and Henry Taylor stamped their authority on the game (and occasionally the CHXW players!). Playing into a stiff wind in the first half, Guy's and St Thomas's were happy to soak up any pressure exerted by CHXW, and to rely on quick breaks by Wallder and McDonogh to pose threats. It was indeed one of these breaks by Wallder that resulted in a corner. Kitey floated the ball over, Tim Buck dummied it, Tony Betts missed it, and up popped Tim McDonogh at the far post to slide the ball in from five yards. As was agreed before the match, Tim was allowed sufficient space to celebrate in style.

Soon after the goal, CHXW had their most dangerous break, but this time it was Billy Jowett, the least experienced player in the defence by a good many years, who cleared the ball and once again the keeper, Julian Thompson, was denied any action. The second half was dominated by Guy's and St Thomas's, and the crowd was unlucky not to see a 'goal bonanza'. It was unfortunate that with twenty minutes to go, Tim McDonogh was injured and despite trying to run it off, it was agreed that 'Supersub' Steve Lewis should come on. In the excitement of the moment, Tim's parting words of 'encouragement' were lost. With almost his first touch,

Steve put John Goodlad through, and his shot was tipped round the post by their keeper. It was appropriate that from the resulting corner John should rise above everyone else and score his first goal of the season. The second substitute, Paul Kalra came on for the last ten minutes, as CHXW pushed their players up in an attempt to score. However, when the final whistle went, Julian still hadn't had a shot to save, and Guy's and St Thomas's had won the oldest cup in world football; and the celebrations began.

A special thanks must go to all the supporters who came down to cheer the team to victory, especially Olly and his bagpipes, Bagwoman Pryke, Roy and Matt whose touchline antics will be remembered by all (except themselves, perhaps!). Mr Crisp must also be thanked for his encouraging half-time remarks—he certainly told everyone what he thought of the performance—and thanks also to the coach company who have served Guy's so well in their Hospital Cup campaigns this year.

Finally, congratulations to the players this year—the first Guy's and St Thomas's football team to win a Hospitals' Cup.

Team: Julian Thompson, Billy Jowett, Tony Betts, Andy Mead, John Goodlad, Henry Taylor, Matt Crisp, Tim Buck, Kitey Hawksworth, Paul Wallder, Tim McDonogh, Steve Lewis, Paul Kalra, Brendan O'Reilly.

Henry Taylor

Sweet victory!

UMDS Mixed Hockey tour

The Tom Jones Tour of Lurve '92.

The tour started at a very slow pace, but once virgin tourists had been weaned off the cokes things got underway. While minibus traumas were being sorted others were 'Touring' in the bar and Valentine's day was going well with roses and poems for certain members! At 8pm the call was made to leave, when unfortunately fifty yards later we were forced to stop due to technical difficulties involving the boys' bus preventing further progress. One hour, kidnaps from both sides and a few gins later the M4 was looking good. After a few more hours we arrived in Cardiff where it was kebabs all round (thanks Nigel).

Saturday morning brought the ultimate goal of... hockey? In rain free subzero conditions the teams set out to conquer Cardiff on the hockey pitch. With 2 goals scored by the converted footballer, the men drew the first match against the local medics, the girls also held their opposition to a 3-3 draw with 'Legs' scoring a hatrick. Mixed hockey was the next item on the agenda and both teams showed their true colours (which contained red this year) with decisive victories of 5-1 and 4-1. Due to a failure in post match interrelations—where was snogger?—it was back to the hospital bar for penalties all round. Another infamous medical student toga party was held on Saturday night, but why all the giggles in the pool room?

Sunday heralded yet more hockey-although were three circmferentials of the hospital really needed before arrival at the pitch-even without Nigel. It was now the turn of Cardiff University to meet the might of London, the match was closely fought with several unnecessary substitutions to allow other recreations on the sideline. Once again a draw was elicited 4-4, would they have beaten Rugby I ask! Post match relations went well and 2 Cardiff students later, a hasty retreat back to London was made. The girls acquired 5 men and the men 1 girl and the tourists were reassembled in the Shoes. Dedicated Path men and women were finally allowed to go to work if they had any textbooks left. All in all the tour was a great success showing Cardiff what UMDS excel at on and off the pitch. Is another University ready to take on the infamous UMDS Mixed Hockey Club tourists?

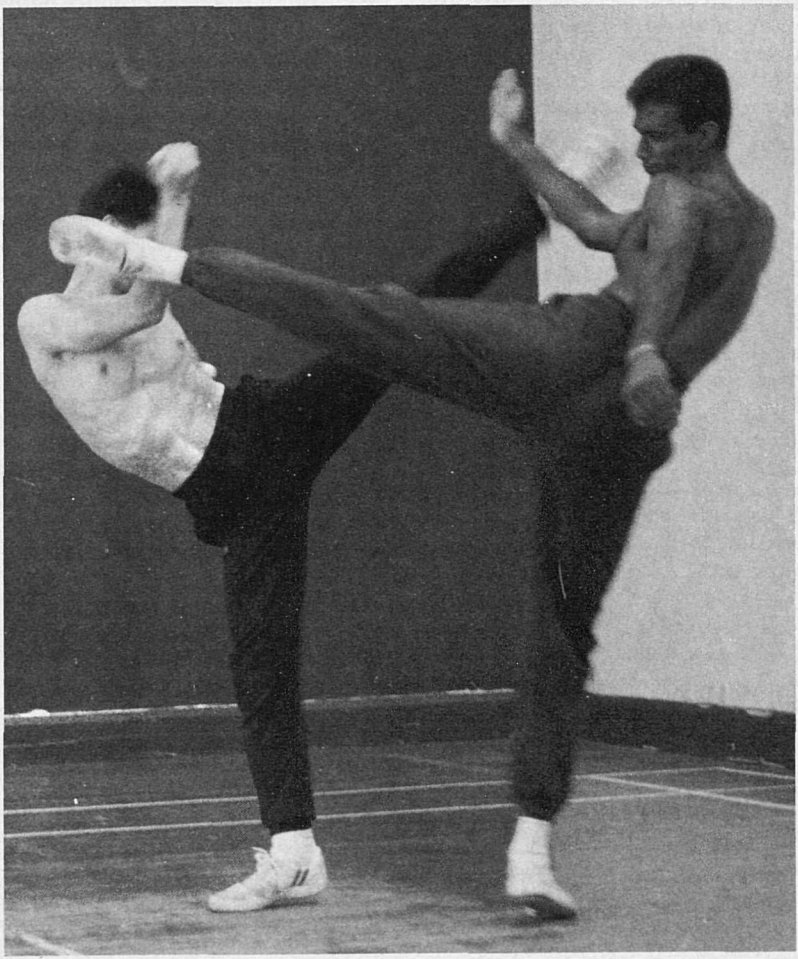
Tourists: Helen Jackson, Penny Grace. Simon, Colin, Grant, Sharps, Bill, Ed, Neil, Guy, Rob, Richard, Ken, Ollie, Curig, Roger. Hels, Penny, Prosser, Catherine, Louise, Rebecca, Harriet, Francis, Hannah, Suj, Katie, Ali, Sara, Kate.

Guy's Martial Arts Club

The Guy's Martial Arts Club meets every wednesday at 17.00 in the Pavy Gym for training sessions and on saturdays at 10.00 for lessons. Our instructor, Mr Ian Davis, is a second Dan in Karate with training in Aikido as well as Wing Chun. He incorporates techniques from Karate, Aikido, Judo, Thai kick-boxing and Boxing into basic Wing Chun movements. The club trains in an informal atmosphere and takes constructive criticism from all members who are encouraged to develop their own styles and perfect the moves

suitable for them. Absolute beginners as well as martial artists with previous training are welcome. You can contact us through the Martial Arts Club pigeon hole on the first floor of Boland House.

Sabrina Tsao
Ladies' Captain



New doctors

The follwing students qualified MB BS (London) in December 1991:

Amin, Miss C L
Amos, H T
Arasu, Miss A
Banerjee, S
Barwell, J R
Bowden, Miss J E
Caine, D J
Caller, Miss H A
Chadwick, Miss F D
Cohen, A R
Davies, N H
Drury, R E F
Egerton, D R
Huggins, Miss E
Lau Lao Ling, Miss B
Mitchell, P D V
Oatham, Miss C E
Penge, Miss D J
Qidwai, Miss A
Shirvani, R
Yousef, Z R

The following student qualified MB BChir (Cantab), in December 1991:

Rutter, H R

The following student qualified LRCP, MRCS in October 1991:

Barwell, J R

New dentists

The following students qualified BDS (London) in December 1991:

Angelescu, Miss S
Bates, Miss C S *
Beck, Miss R L
Beecroft, Miss C L
Bharwani, Miss M
Boden, J M #
Borhan, Miss K
Butt, Miss Z +
Ching, L Y-K
Chok, Y F
Clapp, A J
Colebourne, Miss J S L
Copson, P D
Davenport, N J
Dixon, E J A
Dooley, M J
Doran, J G
Dufu, Miss A A
Friedmann, M E
Griffiths, Miss H S
Harris, G R
Johnson, Miss N C L
Kelley, S S
Kennedy, P J +
Khanna, S
Leach, Miss H A
Macey-Dare, Miss L V
McCullagh, J
McLaughlin, M D
Malik, Miss F
Meakin, J
Murray, T B
Naterwalla, N
Nguyen, Miss N A N
Omell, N S E
Owen, Miss S E *
Page, J R
Parmar, A
Pirbhai, M M
Pourghadiri, M
Prater, B J *
Rankin, Miss C E
Ray, Miss P J
Riddell, Miss E S
Safiullah, S
Sarin, Miss S *
Seal, G J
Sergides, Miss I

Shah, M A
Shirodaria, Miss S
Smith, G I *
Spedding, Miss C A
Swistak, Miss B E
Tam, J O W
Waddington, Miss J C
Willings, M V
Worth, J C
Wright, Mrs A B
Zia, P A

+ Honours in Prosthetic Dentistry
* Honours in Dental Surgery
# Honours in Orthodontics and Paedodontics

Marriage

Katherine Godber, a Guy's physiotherapist 1981-84, to Guy Bainbridge on 21 September 1991.

Death

WALLIS, Winifred died in hospital on 17 February after a period of illness. Winifred was Secretary to the League of Friends for many years, and wife of late Arthur Wallis, Chief Clerk of the medical school until his retirement in 1975. She will be greatly missed by all her family and friends.

Correction

The March issue of the Gazette contained a notice of birth of a daughter to Charles and Ann Clemetson. Ann Clemetson's maiden name was Tuddenham, not Lawson as stated. Apologies to all concerned for the error.

Apology

A number of typographical and other errors were present in the March issue of the *Gazette*. This was due to a misunderstanding between the editor and the printers which resulted in a number of corrections not being incorporated.
A significant number of mistakes consequently appeared in the list of qualified doctors and dentists. This list has been re-printed in full in this issue.
It is regretted if any embarrassment was caused to our readers.

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GUY'S HOSPITAL MEDICAL SCHOOL

Guy's Gazette

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The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

Charity appears to be doing quite well for Guy's, certainly in the last few weeks. The ADT London Marathon chose the Kidney Patient's Association as one of its official charities, and at the time of writing the proceeds from sponsorship money is still being collected.

The Braxton-Hicks fund, Lane-Fox Breath-taking fund and St Christopher's Hospice at Guy's, St Thomas's and Sydenham respectively, are all benefitting from this year's rag week. As this issue goes to press, the usual assortment of collecting-parties and bed-pushers are vying with each other to bring back the maximum returns. The Hit Squad are present in force, as ever, but in line with the changes taking place in the armed forces, there is also an all female Hit Squad available for hire. Some Guy's guys have expressed less reluctance than usual to be the victim of a hit, but for others, the Spit definitely is not the place to be during lunchtimes.

With the unfortunate state of the Park at present, and the mess in the Spit, that doesn't leave very many places to go. The timing of the landscaping of the Park could have been better planned so that it could at least have been appreciated by students during the summer term.

The sixth term has earned the reputation of being a term of idyll for the second year students. Let me take this opportunity to encourage everyone to maintain the energy and enthusiasm shown during rag week, and take advantage of the facilities available to really fulfil the potential of the clubs and societies that exist. That also includes the opportunity to get involved with the production of the *Gazette*. We are always keen to increase the numbers of students involved, and one can participate in a variety of areas. If you're interested, come along and make yourself known.

Genghis replies

Dear Sir,

I feel a need to reply to comments made in the 'Bore Report' about the students bar (*Gazette*, March 1992).

To let everybody know the situation, let me explain; when the bar was renovated in 1990, the students on the committee at the time undertook a loan of £60,000 to the Medical School Finance Department to pay for this renovation. This loan is payable over four years and is interest free. The bar at Guy's has many overheads as I'm sure you all appreciate by this is by far the largest debt we face.

Last year the committee undertook measures to try to meet the first years payment. They fell over £5,000 short of the £15,000 pa instalment. This leaves us with even more to pay for the remaining three years.

We now face a situation where we must take steps to increase our income. Unfortunately the easiest and most reliable way to do so is to increase the bar prices.

A business plan was prepared in conjunction with the Finance Department to project the necessary income we need to make the loan payment. As Cedric Bore pointed out in his comprehensive report this pointed towards a 20p increase on lager and beer and 10p on spirits and bottled beer. To put his mind at rest, the cost of his pint of orange juice is not going up. He was wrong, there will be no increase to the cost of soft drinks, in line with the bar's long running policy of supplying very low cost minerals.

These price rises would (by financial projection) give us sufficient net profit to pay all our debts; something which we currently cannot manage.

Unfortunately this is not the end of the story. Firstly we must allow for the effect of the budget increase, small though it may seem, and secondly our suppliers, who are tied to agreed prices from August to August, will be implementing a rise in time for the Christmas term. This is likely to be between 5-7%. We will therefore have to alter our projections again next year. To lay it on the line; any increase this year may not be the last.

The committee is currently trying to find ways of boosting our income (realistically), eg with regular bar hops, but at the end of the day the money is still coming out of your pockets. At the time of writing the committee was trying to extend the loan period, although this has already been refused once. If however, the loan is extended, it would mean that prices would not have to go up so much but unfortunately, they would still have to go up.

In reply to Cedric's comment on the bar's gross profit margin; the bar has never successfully operated on a 40% GPM until Mr Heggies' appointment as bar manager. The previous committees only ran to a 30-35% GPM and even this intended mark-up fell way short because of so much stock being given away; a fact that Cedric Bore's committee at the time was prepared to turn a blind eye to, and if the bar had operated on a successful 40% GPM at the time, there would be no problem meeting our repayments as there would be money in the kitty.

Now the bar is being properly handled by a manager with twenty years experience in the 'real' licensed trade and we can expect that as soon as our debts are paid off, the students at the time will reap

the benefits with the profits made going into the club's and student's union accounts.

I realise more than anyone, that putting up prices is an unpopular decision. I also realise that although many people will accept the decision and understand why it is necessary, some of you will not be pleased. Therefore let me make something clear; we do not force anybody to drink in the bar and if people who strongly oppose a price-rise (and will not accept financial reasoning or would like to be known as bad debtors) wish to drink elsewhere; nobody will stop you from doing so, but bear in mind that south east London pub prices are likely to be higher than ours.

If anybody wishes to discuss this further with me on an individual basis then I'm usually in the bar at lunchtime, recognisable by the bearskin, pointed hat and spear.

Yours faithfully,

G KHAN Esq
Bar Secretary

Racing pranks

Dear Sir,

I was much amused to see in a recent *Gazette* (December 1991 actually, but we can't be always on parade when old!) the lovely racing car at Brooklands on 9 May 1930—the year of my birth!

I once had the honour to sit at dinner next to a very famous racing driver (he is no longer with us unfortunately, but I am not going to drop names in any case). I asked him why they had fish-tail exhausts in those days. He replied that he didn't know, but he said at least your 'friends' couldn't insert a potato into it! A popular practical joke forty years ago. Life was far more amusing then!

Yours faithfully,

M J FAWCETT, LDS
2 Mill Yard
Natland Mill Beck Lane
Kendal
Cumbria

Biennial dinner

Dear Sir,

It is a great shame to see that the Biennial Dinner is yet again to be held on a Friday. This is no doubt very convenient for those based at Guy's, but what about the rest of us—surely the majority—who live in the sticks and find it difficult to get to London by 7.30pm unless we take a day off work? Why not move it to a Saturday night? I am sure the attendance would go up and make it a more enjoyable event.

I urge everyone who agrees with me, and those who don't to write to the *Gazette* and see if we can get things changed.

Yours faithfully,

CALUM BARTLETT
Flat 5
11 Chesham Place
Brighton

Paeds reply

The late publication of the April *Gazette* has regrettably not allowed the Division of Paediatrics' reply to the comments made by V P D'Off in his letter of April to be included in this issue.

EDITOR

McDonalds at Guy's?

Over the course of the next few months, Guy's is to see a number of changes to its food provisions for staff, students and visitors. The second May bank holiday will see the closure of Keat's Restaurant, and the opening of the newly refurbished Blue Room in the Nurses' Dining Room.

Building work next to A Piece of Cake will shortly be housing A Piece of Naan which will be serving Indian food to take away—so doctors won't have to go too far for their staple diet of curry. A little further in the future, a restaurant and two new coffee shops are planned for the Phase III building.

Even further in the future, there is a possibility of a McDonalds opening. Negotiations are still at an early stage, but the site being considered is that being vacated by Keat's Restaurant.

Keep security in mind

An armed robbery took place at 6pm on Saturday 18 April at A Piece of Cake. The assistant manager was slightly hurt, and the raiders escaped with about £3000.

The following Monday evening, at about 7pm, a nurse was assaulted during a break in the sister's room of a ward in Hunt's House.

Security is currently being upgraded throughout the hospital following an earlier incident on Evelyn Ward several months ago. Wards in the Tower have already been fitted with a video entry system, and work on the remaining wards in the hospital should be complete by the time of publication. Closed circuit security cameras have already been installed in a number of sites, and this scheme will be extended in due course. All staff and students are requested to keep security in mind and to be vigilant at all times. In the event of an emergency such as an assault, security should be 'crash called' by dialling 3333. This will help to ensure a speedier response than bleeping 007 which can be used to report incidents.

MB/PhD programme

The Education Committee of UMDS is hoping to institute a combined MB/PhD course within the next few years. One such course is already available at Cambridge where students obtain a doctorate before finals. It is possible for UMDS students doing a BSc to apply to join the MB/PhD programme at Cambridge, or indeed their conventional clinical course which finishes six months earlier than the London ones.

Deans' suggestions for undergraduate course

The present pre-registration scheme was introduced in 1953. Significant changes in medical practice since then have prompted the Council of Deans of UK Medical Schools to propose a series of changes to the undergraduate clinical training pre-registration year.[1]

The main feature of the proposal is to double the pre-registration period to two years while reducing the undergraduate course by six months. There would be two house officers, a 1st year and 2nd

year HO, for each HO post at present. They would share the clinical work and rotas between them, and separate educational programmes would also need to be instated to ensure adequate experience and teaching.

Such a scheme would immediately reduce junior doctors' hours and workload. It would also reduce earnings, but this would to some extent be compensated for by an earlier entry to the payroll.

These changes are at present only suggestions which are meant as an 'initiative to stimulate debate'. The Pre-clinical Dean, Dr Thomas, stressed that these proposals had not been considered by the General Medical Council who would, of course, have to approve any changes that were to be made.

1 Richards P. *BMJ* 1992;304:625-7

Guy's promised a scanner

The Health Secretary has promised 29 hospitals across the country radiography machines as part of a £20 million government programme against cancer. Guy's is one of the hospitals that is due to get a CT scanner. Other hospitals will have linear accelerators and MRI scanners installed.

New appointment

With effect from 1 April, Mrs Bridget Couch joined Guy's in the capacity of Assistant Director of Domestic and Portering Services. She is based on the 2nd floor of Tabard House, ext 5903.

Lunchtime concerts

Guy's and St Thomas's Music Society is preparing a series of chamber concerts to take place at lunchtimes. These began on Thursday April 30 in Guy's Hospital Chapel with a performance of Mozart's Piano Trio in B flat (KV502). Anyone interested in performing in these concerts or in promoting the musical life of the hospitals is most welcome to contact Angeli Sarathy via the Music Society pigeonhole in Boland House.

New Year Honour

We should have offered our congratulations earlier to two recipients of the CB in the New Year Honours List. Dr Michael Abrams who is Deputy Chief Medical Officer at the Department of Health and is well known at Guy's where he worked for many years in the Department of Medicine as Senior Lecturer and Consultant Physician. Air Vice Marshall John Ernsting is a Guy's graduate who has been associated with the Medical School for a long time. John Ernsting has had a very distinguished career in the Royal Air Force spent mostly at the RAF Establishment, Farnborough where he made many notable contributions to the physiology of flight and high altitude.

Retirement

Mrs Anna Edwards retired from the Guy's Physiotherapy Department on 30 April 1992 after 14 years of service.

Gene screening

A team at the Hammersmith have delivered the first child screened for a specific gene defect before birth—in this case cystic fibrosis.

Sperm and ova were taken from the parents, both carriers, for in vitro fertilization. The fertilized eggs were scanned, and one which was identified as not having the cystic fibrosis gene was implanted in the mother's uterus. The gene was discovered in August 1989, but this is the first time that fertilized eggs have been successfully screened for it.

This technique should offer parents who find termination unacceptable an alternative means of ensuring a successful pregnancy.

Rising fertility in thirtysomethings

In the last 10 years, the fertility rate of women in their late thirties has increased by over 40%. Meanwhile, the rate for women in their twenties has decreased by almost 20%—the lowest in this group since the war. The reversal is largely due to professional couples who are delaying childbearing.

Preterm milk needs

A trial of over 30 preterm infants suggests that feeding on nutrient enriched milk results in better growth (25th centile after nine months feeding) compared with standard term formula (3rd to 10th centile). The enriched formula had more calories, protein, calcium, zinc and certain vitamins than the standard. These results suggest a possible role for specially designed formulas for preterm infants following hospital discharge.

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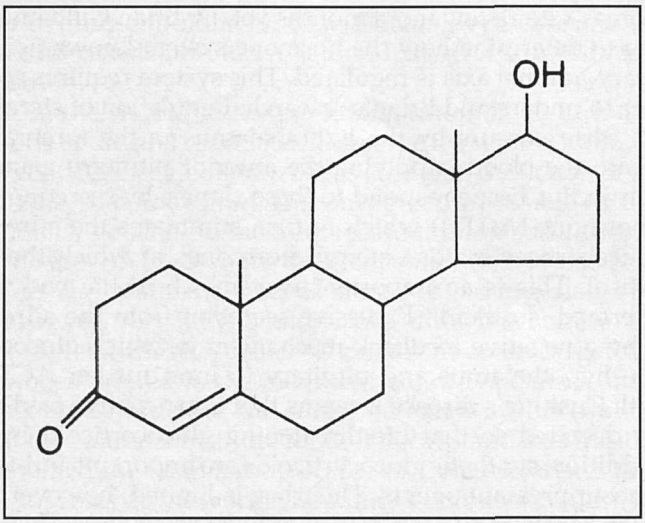
Steroid Hormones and Chicken Wire

The hidden connection

In my previous article about the goings on in the biochemistry department (*Gazette*—November 1991) I mentioned Professor Diplock's involvement in the discovery of the role of selenium in thyroid hormone metabolism. Horomones have, however, been of central interest to the Division for many years on both capmuses, particularly steroids at Guy's and insulin at St Thomas's.

Students will not need telling that steroids—chicken wire, as they were dubbed by my wife many years ago—have been the life-long research interest of Professor D B Gower, who holds a personal chair in this field. The diverse effects of these molecules reflect chemical variation in both the steroid nucleus and the complex arrangement of side chains. Their study requires precise, sensitive and inevitably expensive techinques for separation and identification by capillary gas chromatography and, for the characterization of new molecular structures, mass spectrometry. It is not surprising then that Professor Gower's first academic qualifications are those of a chemist. His long-term programme—unravelling the pathways of androgen biosynthesis in human and animal testis—has taken some unexpected twists beyond the immediate targets of understanding how these hormones are regulated and developing drugs for their control.

One of these, of general interest to everybody, is the need to keep smelly armpits under control. Contributing to this aroma is a group of volatile steroids, called androstenes, with a musk-like or urine-like odour—what a difference one double bond between carbon atoms 16 and 17 can make! These androstenes have a well-established pheromonal effect on the sexual activities of pigs and possibly a more subtle one on ourselves. Experiments suggest that they may modify an individual's judgement, such as seating location in the presence of another pheromone producer, and even such basic physiological activities as the length of their menstrual cycle. The study of androstenes and their bacterial breakdown products, of both social and commercial impor-



Testosterone—one of the subjects of Professor Gower's research

tance, is one area of Professor Gower's research.

It is appropriate that, as organiser of the pre-clinical dental biochemistry course, Professor Gower should also research steroid involvement in dentistry. Surprisingly, the ubiquitous sex steroid testosterone and its metabolite DHT (see your lecture notes for this one!), have target receptors on the the fibroblasts of human gingival (gum) tissue. Unpleasant interactions with normal drug therapy can result, causing the gums to grow over the teeth producing discomfort and affecting dental hygiene. Problems may arise with such diverse treatments as phenytoin (an anticonvulsant used for epilepsy), immunosuppressant therapy following, for example, a kidney transplant, and drugs prescribed for cardiac arrhythmias. As with so many areas of biochemistry only an improvement in our basic understanding of the chemistry involved will resolve these problems.

Since preparing this review Professor Gower has sadly suffered a stroke and has had to seek retirement from active teaching on grounds of ill health. However, he intends to continue his research here, and later at the London Hospital Medical College, at a reduced level. He goes with the support and sympathy of us all.

At St Thomas's, for a few more months yet, Dr Brian Gillham and his team are working to determine how the hormone system known as the hypothalamo-pituitary-adrenal axis is regulated. This system requires some explanation in order to understand Brian's research. Regulation of steroid release by the adrenal cortex occurs by the hypothalamus in the forebrain, releasing hormones into the blood supplying the anterior pituitary gland. The corticotroph cells in this tissue respond to these signals by secreting adrenocorticotrophic hormone (ACTH) which in turn stimulates the adrenal cortex to produce glucocorticosteroids—steroid hormones of which the chief one in man is cortisol. This is an important way in which the body responds to situations termed 'stressful'. Excessive secretion from the adrenal cortex is prevented by a negative feedback mechanism in which glucocorticoids act back on the hypothalamus and pituitary to limit further ACTH relase. In patients with Cushing's disease it seems that this negative feedback signal is improperly decoded so that life-threatening glucocorticoid hypersecretion occurs. In addition, synthetic glucocorticoids are important anti-inflammatory and immunosuppressant agents. Their use is limited, however, because patients receiving them may not subsequently respond appropriately to stress. This is because the pituitary (and the hypothalamus) wrongly interprets the drug as a negative feedback signal. Thus Brian's research goal of elucidating the complex mechanisms underlying the secretion of ACTH and its control by glucocorticoids is clearly of medical importance.

The traditional view of steroid hormone action has been that these molecules act directly on the nucleus to alter the cellular phenotype. These changes occur relatively slowly, and certainly underlie the pharmacological effect of large doses of glucocorticoids. In addition, by using ACTH secreting cells in culture, Dr Gillham has shown that the synthesis and secretion of the hormone can be rapidly influenced by physiological concentrations of glucocorticoids acting in more subtle ways. These fast effects of the steroids include changes in the molecular form of ACTH secreted, such that the molecules released have a greatly reduced ability to stimulate the adrenal gland. In addition, the release process itself appears to be rapidly disrupted in corticotrophs exposed to glucocorticoids, and this may well involve alterations in the permeability of the cells to calcium ions. Calcium ion uptake is required for the secretion of hormones.

To study this aspect, Brian, in conjunction with Dr A M Gurney, an electrophysiologist, is currently measuring how glucocorticoids modulate the hormone stimulation of calcium ion uptake by corticotrophs. A detailed understanding of these mechanisms should lead to the development of new

strategies for treating conditions such as Cushing's disease and ultimately to the use of steroid based anti-inflammatory drugs free from adverse effects on pituitary function.

Moving from the steroid to the peptide hormones, we turn to Dr Barbara Moreland—one of the first graduates to emerge from the new BSc in biochemistry at University College London. She is studying the action of the synthetic growth hormone, somatotrophin. This only became possible with its commercial production by genetic engineering techniques. In addition to being used to promote the growth of pituitary deficient children, it is also being tested in clinical trials for the treatment of burns, fractures and in geriatric preventative medicine. However, very little is known about the biochemical effects of the hormone on skeletal muscle, which is one of its main target tissues. Most studies have been limited to the measurement of bone mass and changes in fibre size and types. Much of the earlier research in this country has been carried out at the National Institute for Biological Standards in North London, and Barbara joined the team led by Professor Denis Schulster to introduce a biochemical approach to the work. The strategy employs modern recombinant DNA technology. Copy DNA (cDNA) and oligonucleotide probes are being developed to detect the production of the messenger RNA for new proteins in response to somatotrophin administration. This will enable the machinery for energy production—the much maligned (by both students and consultants) glycolysis and Krebs cycle pathways—and muscle contraction to be monitored.

An aspect of hormone treatment of particular medical interest is the deposition of excess collagen within the muscle. Specific mRNA probes make it possible to both identify and quantify the collagen type involved. As both growth hormone status and excess collagen deposition have been linked with the incurable hereditary disease, Duchenne muscular dystrophy, it is important to identify the molecular events linking these changes to the regulation of muscle metabolism. Dr Moreland is helped in this research by Vicky Wilson.

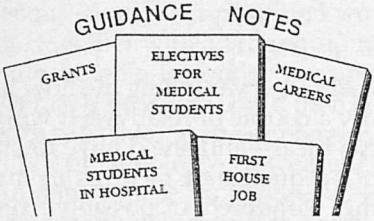
Studies of diabetes at Guy's go back to Dr Pavy (of the gymnasium) in the mid-nineteenth century when daily in the ward he had students assaying the sugar level in the urine from affected patients. Even if it had no therapeutic benefit it must have helped patient morale to watch the dusky red copper oxide magically appear as blue ammoniacal copper solution was run into steaming clouds of boiling urine! Pavy's solution, later called Benedict's reagent after its first inventor, continued in use until quite recently, and is in fact the chemical basis of some strip tests. As with all hormones, the precise regulation of insulin level is central to its mode of action. Research on this topic

in the Division lies in the hands of our Pre-clinical Dean Dr J Hywel Thomas, a product of the University of Wales at Cardiff. He combines his administrative duties with investigating the central role of the kidney in regulating the circulating level of insulin, in order to determine the enzymic mechanism involved. Glomerular structure and function is known to be altered in diabetes mellitus and Dr Thomas' recent studies indicate that the mechanism responsible for the altered glomerular haemodynamics seen in diabetes involves cyclic AMP. In conjunction with Dr D R Davies of the Histopathology Department, he has also developed techniques for the experimental induction of glomerular disease. These have revealed that the changes and molecular size of an antigen are important determinants of its glomerular penetration and capacity to induce glomerulonephritis. It was previously believed that immune complexes, once deposited, were removed only by mesangial cells; Dr Thomas has shown that endothelial cells are also capable of endocytosis, and the mechanisms involved are currently under investigation.

In the early stages of the research Dr Thomas was joined by Dr Despo Papachristodoulou to study the degradative metabolism of insulin in the liver and kidney and, of related importance, the regulation of protein synthesis and degradation in muscle. Graduating at Bexford College in Regents Park, Despo subsequently studied diabetic retinopathy at University College Hospital Medical School. It was shortly after this that it was confirmed that insulin could be internalized by pinocytosis and probably degraded via lysosomes. At present, the heavy administrative burden of looking after the BMS Part II biochemistry teaching rarely allows her time on the bench.

D C Watts

BMA



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Problems with the Waterworks

Going beyond the pail

One of my patients—a lively 87 year old—was telling me how little she relished the prospect of a visit by a couple of relatives. It would be a lot of extra work; they'd expect a meal—and she'd have to entertain them. This thought alone conjured up a sequence of pictures in my head; would she give them her Lady MacBeth, I wondered, or possibly a rendition from the prologue of *Henry V*.

'Why don't you,' I began, 'pretend—just for once—that you're a very old lady? You could wear black, down to the ankles and up to the throat, a hat maybe with a veil preferably, and lean on a silver topped cane as you sat on one of those splendid NHS-type incontinence pads in one of your excellent Louise 'Quinze' chairs? You could leave a few saucers of stale urine on the window sills and then offer them a meal. They'd be only too glad to leave you quickly—and you'd be saved a deal of trouble.'

I painted a somewhat dire picture of old age and some of its more lurid accompaniments, but for many, the presence of a commode in the bedchamber is the last straw; a sign that the end is nigh and they can already hear the beating of the hooves of the Four Horsemen of the Apocalypse bearing down on them. It is—shall we say—definitely beyond the pail.

There was another lady of the same vintage—and well placed—with the nurses constantly in attendance, who developed a liking for an item called *Aspects of Love* by Andrew Lloyd Weber, the well known writer of hit musicals. Hardly a day passed when I did not interrupt a performance of the thing on her ghetto-blaster which she played with all the exuberance of an erstwhile Rastafarian walking down Bromley High Street. It was always hard to hold a conversation whilst this musical cacophony took place and one of my happier duties was to press the 'STOP' button on this machine. One day, someone—not me—had a bright idea. Wouldn't it be nice if my patient could actually go to London and see *Aspects of Love*? It would take some planning, but the wheel-chair and the Rolls would get her there alright. The nursing team would be

there in force, of course, and delighted to see the show for free. The one snag was raised by me.

'What about visits to the cloakroom?' I ventured.

'No worries,' came the reply—for the nurses were all from 'down under'; 'We'll catheterize her.' At that moment, I had the urge to write to Lloyd Weber and tell him that one of his greatest fans was prepared to be catheterised so she could see his musical in its entirety. I spoke to her on the matter and she seemed very happy with all the arrangements. It was then that I made my confession—that in her position I would have taken a consultant anaesthetist with me together with all the equipment needed, and at the onset of the show he would be able to render me unconscious and duly set me up on a life support machine which could then be discontinued at the end of the performance with me waking up—preferably—and saying: 'Is it over yet?' When she came to it, the whole event went off without a hitch and she was duly fixed up with one of those arrangements—'as worn by Royalty'—and enjoyed the occasion enormously whilst the nurses looked at me askance as though I was something of a philistine.

Musical taste is a very subtle thing as I discovered when chatting with the coach driver on my way up to some freebie-type 'do' laid on by an organisation which must remain anonymous. I admired his collection of tapes and he said:

'Yes, me and the wife like classical music.'

There was a pause as he changed gear, and then he said:

'Yes, we listen to a lot of Richard Cleyderman, you know.'

I saw a very racy performance of *Don Giovani* a while back and the audience were so attentive that it was difficult to unwrap a boiled sweet without being nudged and shushed by everyone about me. Meanwhile, my wife—Jacqui—was enjoying one of her coughing fits which we managed to silence quite well with a series of handkerchiefs strategically placed over her mouth. Some of the scenes of full frontal nudity had me reaching for the opera glasses only to realise that I hadn't the right-shaped coin about my person. On the other hand, we had a super evening when we went to see *Me and My Girl* and there was some thoroughly decent music there, with tunes a fellow could tap his foot to. There's no accounting for taste!

We live in the days of the trans-urethral resection which I renamed 'the trans-Siberian resection' in an attempt to jollify a somewhat worrying operation for the chaps—and it's a wonderful thing; seeing what men like Michael Joyce and Ian Higton can do once they're at the helm of this rather complex-looking piece of kit. The theatre is darkened and they take on a role not unlike that of a latterday submarine commander as they practice what I see as a form

of under-water surgery.

What they see is a mystery to me, but the post-operative plumbing always looks colourful and provides a talking point whenever I pay one of my visits to the bedside. I never sit on the bed on these occasions in case I trip over some tubing or incur some further hazard as a result of treading on—or in—something. In the sixties, there was Millin's operation, the retro-pubic prostatectomy, and what a wonderful chance it was for the surgeon to show a clean pair of heels. The self-retaining catheter with the 10ml blow up bulb was yet to come and red rubber tubing was the order of the day—gulp! It was self-retaining by virtue of the thick blue nylon rope which came up from the tattered remnants of whatever had happened, through the tissues, and out through the skin just below the scar—or to one side depending on whether the incision had been vertical or horizontal. The nylon was 'capped' by an aluminium-style button which squeezed the ends together and indicated that the catheter was tied into place. When the time came to remove the catheter it was the work of a moment to cut the button off and pull the catheter out, although there was one occasion I can recall when an attempt was made to remove the catheter without doing this first. The recipient of this misfortune yelped a bit and the whole occasion may have looked like a bit of a cock-up—excuse the pun—but that man is alive and well and claims that he is still potent! A remarkable achievement all round when one considers that we are all twenty-five years older.

Only recently, I was talking with a 96 year old man who regaled me with the true story of his uncle—a medical man—who had to catheterize himself every time he wished to pass water for the last 25 years of his life. In the days before prostatic surgery, the prognosis was only three months or so due to germs getting in and fouling up the works, and it was a miserable way of carrying on but there was nothing else to be done. Doctors traditionally carried their catheters in their top hats, as did their more affluent patients. The hapless patient had to lubricate the catheter with his own saliva—yuk!

Of course, we have the KY jelly now—but then everyone has KY jelly and I would tend to advocate that it should be sold with a small fire-extinguisher in these times of the enthusiastic amateur. Last week, I presented a psychotherapist with a tube of the stuff. It has an important use in certain situations which I shall not begin to describe here, and this man—a psychosexual counsellor—had never had cause to handle a tube of KY jelly.

'Allow me to present you with some,' I said. You'd have thought I'd just handed him a hot potato.

'There we are,' I enthused, 'now you can go off...and play with it.'

I was on Mr Kilpatrick's firm and he was a quite pleasant man who taught me a lot of things that aren't in the books even now, and that have stood me in good stead. The outpatient sessions tended to go on a bit though, and there was one where I had foregone any hope of getting to it as I had foolishly taken 28 units of ethanol the night before. It was the Mann/ Scott/ Clark firm dinner, and it had been an excellent evening, and at ten pints I would have thought it was time to stop. However, at that stage someone tried to make me a Cardinal, and when I was Cardinal Puff-Puff-Puff for the third time, I knew I had to draw stumps and totter back to the proverbial Pavilion. At two in the morning, a fellow student, Angela Walker, led me to my own front door, out the key in, pushed me through the door, and posted the key through the letter-box after me. What followed afterwards is forever gone but I must have made it to bed alright and slept until something crashed onto the floor. Whether it was me or something else, I have no idea. A light went on as my mother came to investigate the source of the noise, and I got up and walked past her and into my parents' bedroom where I stood in the alcove over their wash-basin.

'What's he doing, Frank?' asked my mother. Happily my father was at a loss for words. The awakening the same morning produced a hangover of such cataclysmic proportions that I doubted if I would ever get to Guy's that day—or ever again. I did make it to 'Kilp's 'outpatients for 2pm and then sat tight for the next three hours waiting for things to get better. By 6pm, I had a great hunger and it was time to make for the Spit once more. A good square meal set me up and so life went on. Alcoholic gastritis seems to have been one of the snags of student life, and it was a miserable thing when it happened. Always—with me—it happened on a Monday, but then I had recourse to an old family standby viz bismuth and soda which works wonders in only a short time. We used to make it up by the Winchester bottle full, shake it and dilute 2:1 when pouring it into the bottles. Due to the photosensitive properties of bismuth salts, it tended to go black if left in the daylight. When bismuth carbonate reached £4.00 per pound *avoirdupois* it was no longer a bargain at two and six a bottle. The formula was a mixture of bismuth carbonate, sodium bicarbonate, peppermint water, and a few drops of chloroform water. A mouthful of that straight from the bottle would produce a good belch and relief from symptoms by the end of the morning.

There were a lot of urethral strictures about and there was one in our practice. He lived to be 97 and had celebrated the night the news came through that Mafeking had been relieved— by making it with a lady who had a touch of the gonococcus about her person. Thereafter, he was visited in the usual way some 48 hours later and for the rest of his life had regular visitations from

the *bougies*. The older he became, the happier his memory of the whole occasion, and he never tired of telling the story to whoever was prepared to listen. Much as his urethral stricture reminded him of the night Mafeking was relieved, so that historical event reminds me of this old chap and his wonderful story. I am sure that Baden-Powell would have slapped his wrists soundly!

There are many fine old characters to be found in the follow-up cystoscopy section of medical life. I lost one such some two years back. During the last war, he had led one of the last sword charges whilst seconded to the French Foreign Legion, been decorated with the *Croix de Guerre* by de Gaulle, and put up for a DSO which he didn't get. He knew his number was up and these facts emerged during the last conversation we ever had. Like the good Guy's patient he was, he simply faded away.

I always felt sorry for the chaps who got a paraphimosis—and it always appeared to happen during the hours of daylight under unusual circumstances, and for all those men with an untreated phimosis who are accidents just waiting to happen. Peryonies's disease is a tricky thing, and we never get to see the trouble unless the fellow has a Polaroid camera; not a piece of kit that the average man would rush out and buy just for one shot of things at their worst.

There are a surprising number of men walking about with hernias who refuse surgery. Though their trusses have long since given up the ghost, they wear them still, and one 84 year old strangulated his hernia while playing tennis at the local club.

'Did you win?' I asked. Yes—he did win, but he was lucky enough not to lose some guts (even though he was not lacking in them having won a MC in the trenches during the First World War).

I am still draining a hydrocele once every three months in an eighty-nine year old who has sported his for some twenty-five years now. Gone are the days of the trochar and cannula as I opted for the much more twee Butterfly-21 with its piece of plastic pipe attached to a 20ml syringe. Even though he lives at Bexhill-on-Sea, he is still prepared to make the journey up to Beckenham to have it done. Last summer, he had a stroke, and my wife and I went to see him at his flat overlooking the sea. After I'd tapped his hydrocele, we all sat and had tea, with cakes; and very nice it was too!

J H Pitt-Payne

Guy's Hospital Gazette

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Philip Harris House

Work on Phase III continues

Amidst the other numerous changes at Guy's over the last few weeks, work on the Philip Harris House continues, veiled from curious eyes by green netting. The site has been dogged by various unforseen problems. The most recent of these was the discovery of a suspect metal object whilst digging, which was thought to be an unexploded bomb—buried during the war. Works were held up for some days, until it was established that the object was in fact a girder. On a historical note, the area was once a graveyard, and hence, officially, before building could commence the remains of those buried there had to be exhumed, under Home Office regulations.

The building will be of seven floors, plus basement, with the top two floors serving maintenance functions (Figure 1). The lower ground floor will become new kitchens—serving the whole hospital—plus a dining room, which will be without windows or a view, but is promised to be attractive and appealing.

The remaining five floors are a combination of outpatient clinics, wards, clinical services and academic departments. These departments are arranged to facilitate ease of access for patients using them, staff that work in them, and to approximate departments which are clinically and academically related.

There will be one main entrance, which will serve this building and the tower, and will be adorned by the memorial arch (*Gazette*, February 1992); plus separate entrances for the genitourinary medicine clinic, and for the Geriatric Day Hospital and psychiatric unit.

The departments with the greatest throughput and those which require easy access are placed on the ground floor. This includes obstetrics and gynaecology outpatient's, pharmacy, medical and social work, and rehabilitation departments. The geriatric day hospital will be moved from the remains of New Cross Hospital, and will have it's own ambulance drop off point.

Three covered gardens will be on the ground floor, with views down on them from the floors above. These covered gardens will be associated on the ground floor with departments that will appreciate the facility most, that is, the geriatric day hospital, physiotherapy, the psychiatric day hospital, and an outpatient's buffet. The final style of these gardens is not entirely decided but an artist's impression of the basic idea is shown (Figure 2). The old tower

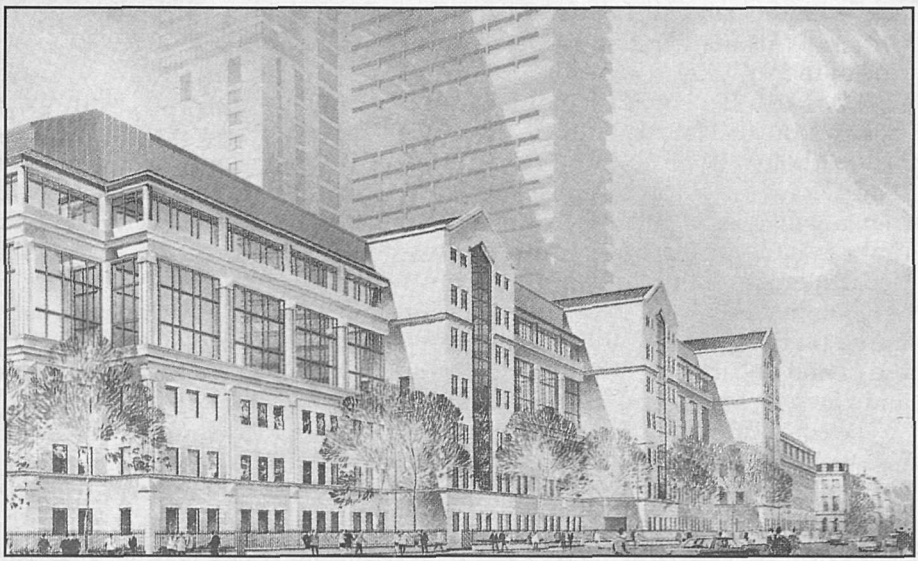


Figure 1. Philip Harris House from the outside

reception will become the new Salomon's Centre and will connect with the walkways of the Philip Harris House.

The departments to be placed on the first floor are those which have greatest claim to a need to be near the theatres of the Tower and New Guy's House. These are: the new intensive care unit, a cardiac investigations unit, and the associated cardiothoracic wards and outpatients. The paediatric outpatients department is strategically placed near the ophthalmology and cardiology departments on this floor.

The second floor will predominantly consist of departments which will run day services and hence will have a large thoroughfare. These include: an acute day unit, the departments of endocrinology, diabetes and chest medicine (with the clinics and wards closely linked to make best use of staffing resources).

Though the genitourinary medicine clinic will be on this floor also, it will have it's own entrance, directly from the walkway coming off London Bridge.

The third floor will consist of dermatology, ENT, and audiology clinics, with their associated wards; and the oncology department (clinic, wards, and probably most of the academic oncology department with ICRF labs) associ-

ated with the pain relief department. An adult psychiatry ward will occupy a corner of this floor, with a six bed intensive care unit—on the Weston Street side of the building.

The fourth floor will be occupied by departments associated with those facilities on the fourth floor of the Tower and New Guy's House. Hence histopathology will be here, close to the other clinical pathology services (haematology, clinical chemistry etc). The renal and rheumatology departments will also be on this floor and hence be near to the tissue typing and dialysis units in the tower. Also on this floor will be the clinical teaching departments and the academic department of psychiatry.

Floor five will be purely academic, including the departments currently found on the 17th and 18th floors of the Tower, which will be taken over by the dental department. Thus the academic departments of medicine, asthma and allergy, radiological sciences and many more will be found here.

The completion of Phase III will be associated with many other changes at Guy's. The current kitchens, on being replaced, will become a new site for Central Stores, with an unobtrusive delivery bay in Weston Street. The one way system, and exit into St Thomas' Street will be abolished, when the outpatient's building is demolished to make room for a two way turning circle; and the exit into St Thomas's Street will no longer exist and the stairs from London Bridge will occupy the centre of the road, instead of being pushed against the walls of Boland House. Other changes to be expected at Guy's soon, are: a Movement Laboratory in the Newcomen Centre (for management of cerebral palsy patients), funded by the East End Community Trust, which should open around Christmas this year; and the long-overdue upgrading of the radiotherapy department in the basement of New Guy's House.

We can look forward to Philip Harris House being ready by December 1993, with the final cost estimated at £118 million.

(Further information can be obtained from Sandra Carnall, in Conybeare House).

HM

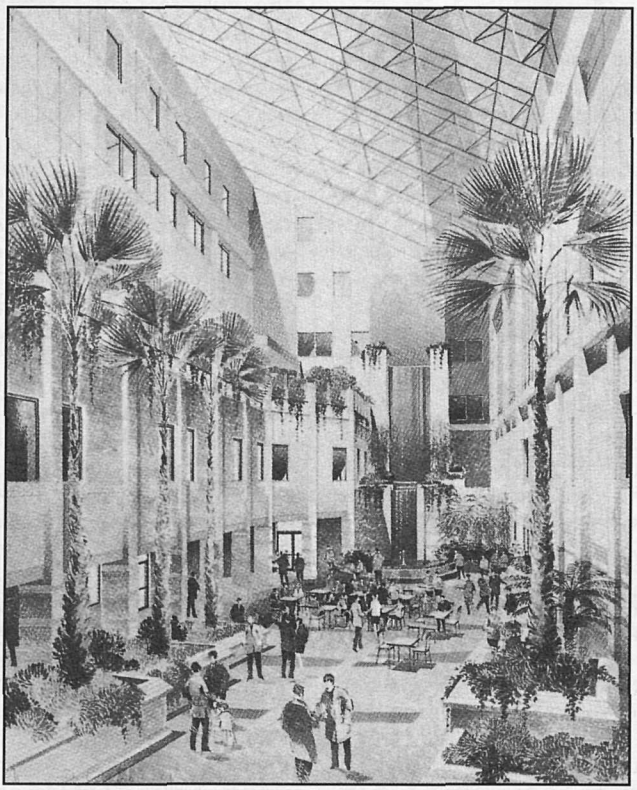


Figure 2. 'A calm oasis in a busy hospital'

"Quote-Unquote"

Two students remarking on the artist's impression above.

First student: 'It doesn't look much like a hospital...its more like a shopping centre.'

Second student: 'Precisely!'

Surgery

Pye's Surgical Handicraft. 22nd Edition by J Kyle, J A R Smith, D Johnston. Published by Butterworth and Heinemann. Price £22.50

James Kyle, a consultant surgeon at Aberdeen Royal Infirmary, has been the editor of this volume for the past 30 years or so. My first acquaintance with this text was when I was asked to review it some weeks back. I immediately rose to the challenge since I was doing a fairly light casualty job and the title of the book conveys a very practical hands-on approach to surgery. After going through 450 pages of verbose text my first impressions were not fulfilled. This is most certainly not a text to consume from cover to cover—both the style and contents of the text are not appropriate. How many of us would appreciate a twelve page dissertation on treatment of snake bite? Even in remote Roehampton I have never had to quiz patients on whether the bite on their finger was from a *Elapidae* or an *Atractaspididae*.

The only explanations I can offer for my dislike of the style and content of this text is because it was not written for your average local medical student or junior doctor. As stated in the preface 'the advice given in this 22nd edition should be useful in any part of the world'. Hence the importance of distinguishing between the *Viperidae* and the *Colubridae* snake bite. In contrast the chapter on major civil accidents is a miserly four pages long and is about as useful as the instructions for opening a milk carton without spilling the milk.

It would be unfair to assume that the book has nothing to offer the local medical student or junior doctor. Indeed the very nature of the book's wider world audience ensures that the text is clear and simply written, albeit verbose. There are some excellent chapters which live up to the name of *Surgical Handicraft*. There are chapters on minor procedures, wounds and minor surgery, and local and regional anaesthesia which are useful. There are some good chapters on orthopaedic techniques, injuries of the limbs and fractures and dislocations. There are also a number of management chapters—management of cardiothoracic, gastrointestinal, biliary, pancreatic and anorectal cases. Although these chapters contains some useful information you have to extract this from a monotony of text. There are no tables or summaries to help you. What is useful however are the many pictures of instruments and procedures scattered throughout the book. A quick glance at these before exams would enable one to talk with some authenticity about practical procedures that is sometimes lacking in the final MB,BS. Nothing however, can hope to match the experience of having done it yourself.

I would only say that although some useful information and guidance is contained within this text, the same information is available elsewhere, more concisely and in more extractable format.

I F Hussain
SHO in Accident and Emergency

Pharmacology

Basic Pharmacology. 3rd Edition, Foster. Published by Butterworth Heinemann. Price £15.95

In 1980 when *Basic Pharmacology* was first published it was a breath of fresh air in student texts. It is aimed at medical, dental, pharmacy and nursing students and the competition at that time was provided by traditional and, although perfectly adequate, rather dull texts such as Gaddum's or Lewis's *Pharmacology*. The approach of the new book was very much student centred, with aims set out at the beginning of each chapter and a modern layout that was pleasing to the eye.

The question now, some twelve years on, is does it still retain its sparkle, and how does it match up to the competition? Well, it retains the same layout, which even now appears modern, there is plenty of 'white space' and the same conventions used in previous editions are still followed. In particular, drugs listed in the *BNF* are shown in italics and drugs which typify a group are shown in bold type.

The book is divided into only eight chapters which has lead to some rather unconventional groupings of drugs. The first chapter is general pharmacology which deals briefly, but adequately for most medical and dental students, with aspects of receptor action, dose-response relationships, adverse reactions, interactions, etc. The second deals with the action of drugs on peripheral excitable tissues, essentially the traditional aspects of receptor pharmacology within the motor and autonomic nervous systems; whilst the third considers those drugs having actions not related to those concepts, for example, cardiac glycosides, local anaesthetics and anticoagulants etc. This grouping is more than a little confusing because of the diverse therapeutic use of the drugs described. The system of grouping becomes, in my opinion, even less acceptable on discovering that histamine, eicosanoids and anti-inflammatory drugs are discussed under endocrinology; and quite unacceptable and misleading when one finds chemotherapy of malignant disease under parasitic chemotherapy. I can appreciate the reasons for such clusters, but students may find it less than helpful. Two further chapters deal in a more conventional manner with the drugs acting on the central nervous system and with drug disposition. The eighth and final chapter is entitled clinical pharmacology and deals with a number of items which, because of the themes used in the other chapters, have been neglected. Whilst the information in these sections has been presented well, I would have preferred to see it appended to the appropriate section elsewhere (for example, drugs in joint disease with anti-inflammatory drugs), and why discuss epilepsy here and yet Parkinson's disease in the chapter on the CNS?

Once you have mastered this unconventional approach, the quality of information is generally good with a succinct style much appreciated by hard-pressed students. Authors of student texts have a difficult balance to strike between the didactic factual presentation at the one extreme (often pruned to a minimum for examination revision purposes) and the detailed discussion of evidence relating to mechanisms at the other. On the whole Foster sits slightly off-centre towards the former and as such is regarded by many

students as a less daunting alternative to Grundy's *Lecture Notes on Pharmacology* or the more comprehensive Rang and Dale's *Pharmacology*. In fairness, I should add that the new edition of Rang and Dale now includes summaries of the main points which make it easier to follow.

In conclusion, let me say that Foster and his colleagues at Manchester have continued to maintain a high standard. It is a book that I like and will certainly recommend.

Bryan Robinson
Senior Lecturer in Pharmacology

OBITUARIES

Neville Southwell
MD FRCP

Dr Neville Southwell, a distinguished physician, who had many friends at Guy's died aged 76 on 21 February.

Neville Southwell was educated at Oundle School, Cambridge, and the Middlesex Hospital, qualifying in 1940. Because of severe asthma he was not accepted for service in the armed forces so undertook several house appointments before, in December 1941, becoming house physician to Dr (later Sir) Geoffrey Marshall at the Brompton Hospital. Later he became medical registrar at the Brompton where he remained for two years before being appointed medical registrar and Tutor at Guy's. He held this appointment for nearly four years and then became registrar in the chest department which he virtually ran himself in the absence of Dr (later Sir Rowan) Boland, abroad on active service. In 1950 he was appointed consultant physician at Orpington and Sevenoaks where he remained until his retirement in 1981. Although not originally a Guy's man Neville forged strong links with Guy's during the War which were never subsequently broken. He played a very important role in the running of the hospital, and in the care of patients, throughout the war years and would sometimes describe graphically how he had seen flames licking around the hospital buildings after air raids when there was little or no water to put them out. He was and remained a marvellous teacher of medicine and for this many former students remember him with gratitude. He was very kind to his junior colleagues many of whom, re-

turning after the War, he helped gain the MRCP through the excellence of his clinical teaching.

After moving to Kent where he became a much sought after and greatly respected physician , he maintained contact with Guy's through his many friends here and also the large number of junior staff who worked with him who had trained at Guy's. He always remained on friendly terms with his younger colleagues, and was proud of the subsequent success of many of them in Britain and abroad. He was a senior member of a clinical trials group called the Guy's Graduate's Clinical Research Groups which for many years undertook clinical trials of drugs in several hospitals throughout the south-east region. He also frequently attended the combined rounds on Friday afternoons, presenting with great elegance fascinating cases that he had encountered including, on one occasion many years ago, the first patient with bird fancier's lung to be seen at Guy's, Neville was essentially a general physician but because of his early training, the fact that he himself was a life-long sufferer from asthma, and his own particular interests, he was drawn to diseases of the chest and to asthma in particular. He had a huge, and immensely successful, private practice in London which he maintained long after his retirement and was still seeing some patients only a few days before his death.

His latter years were marked by serious problems with his health which he took in his stride and tolerated with indomitable courage and good humour. He was one of those rare people who always made one feel better for having met him. This greatly loved man had a large and happy family and an enormous circle of friends, all of whom will miss him.

RKK

John Tomkinson

John Tomkinson died on 11 April aged 76. He had a hip replacement operation eighteen months ago complicated by a deep venous thrombosis of one leg, but his sudden death cames as a shock to his family and friends.

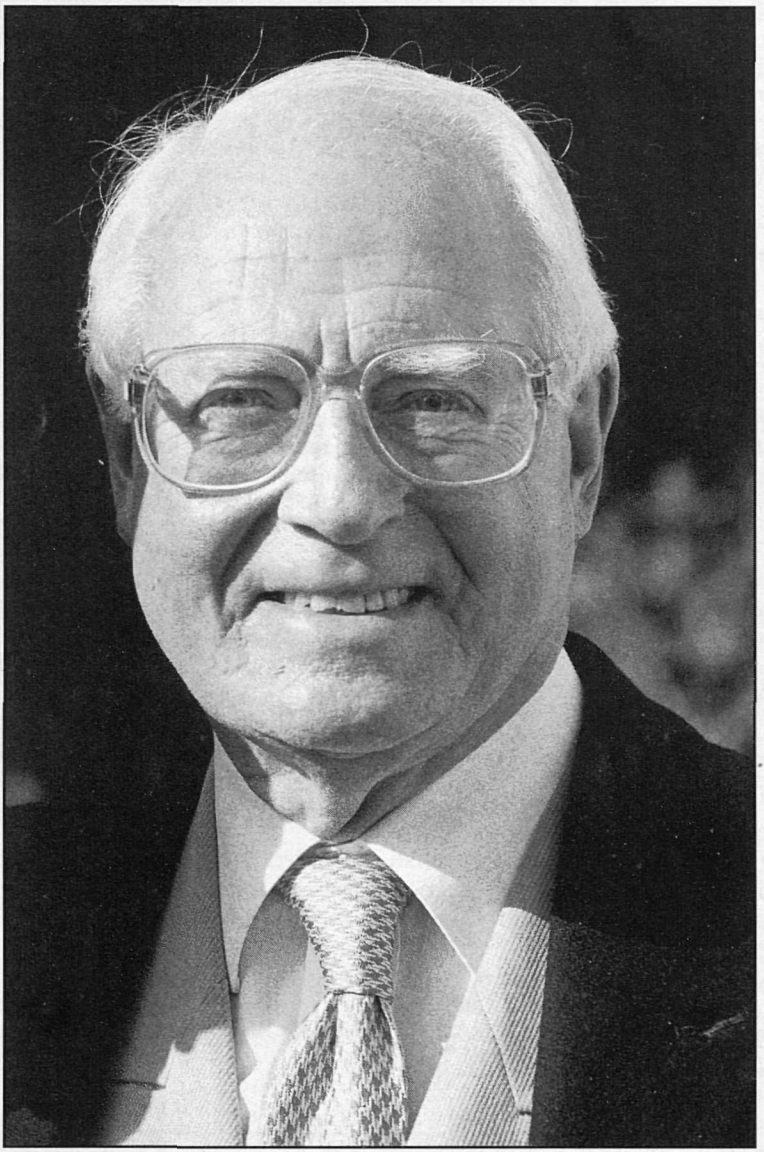
John came to Guy's as a consultant obstetrician and gynaecologist in 1953. He had been to Rydal School and the University of Birmingham School of Medicine, qualifying MB,ChB in 1941. From 1942-46 he served in the RNVR as Surgeon-Lieutenant. He returned to Birmingham after the war and did house and registrar appointments in general surgery and in obstetrics and gynaecology.Dame Hilda Lloyd, who subsequently became president of the Royal College of Obstetrics and Gynaecology, took John under her wing and saw to it that he perfected the surgical techniques which accounted for his prowess as a gynaecological surgeon. In 1952 he became resident obstetrician at Queen Charlotte's Maternity Hospital, until his appointment to Guy's staff in 1953. One year later in March 1954 he married Barbara.

John began his career at Guy's in accordance with tradition living in St Thomas' Street, so as to be within a short distance of the labour ward in Victoria. He and Tom Lewis joined forces in private practice in Harley Street, sharing rooms and secretaries, which their colleagues foretold would last only a few weeks or months. Thirty years later in 1983, they both retired still on speaking terms and completely satisfied with the arrangement.

John threw himself wholeheartedly into the life at Guy's becoming Director of the Department of Obstetrics and President of the Athletic Club. In 1966 he became consultant adviser to the DHSS. He was co-author of five editions of *Confidential Enquiries into Maternal Death in England and Wales* from 1964-78. Each edition contained a detailed analysis of all maternal deaths for three years stating when the authors considered that the deaths were avoidable due to errors on the part of the hospital, the doctor or the patient. The confidential enquiries began in 1952, one of the earliest examples of clinical audit on a national scale. They continue to this day.

In 1976 John was made Secretary-General of the International Federation of Gynaecology and Obstetrics (FIGO), a body responsible, among other things, for organising the World Congress in obstetrics and gynaecology every three years, each time in a different country. This meant international recognition for John. He lectured mainly on the subject of maternal death, in countries round the world, and was made an honourary fellow of gynaecological societies in America, Canada, Colombia, Nigeria, South Africa, Brazil, Jordan, Korea, Italy, Spain, Poland and Romania. He served on the Council of the RCOG from 1960 to 1971 and was a co-opted member of the Council of the RCS and Deputy Chairman of the Central Midwives Board. He was the only British member of the Continental Gynaecological Club of America and an enthusiastic member of the Gynaecological Club of Great Britain. In 1981 he was honoured with the CBE.

A long distance runner in his youth, he took up fishing later and spent many happy hours wading in the Spey in Scotland and on the banks of the Test in



Hampshire. It was in Hampshire that he and Barbara bought a delightful cottage which incorporated a converted Methodist Chapel, so as to be near to his trout-fishing and he also became a member of the Flyfishers' Club in Picadilly.

Although his professional commitments, a busy private practice and a keen interest in the arts kept him fully occupied, involving much travelling abroad, John kept time for his family. Sadly his son Barnaby was killed in an accident in 1986 when he was 29 years old. He is survived by his wife Barbara, his daughter Claudia, now Mrs Finlay, and his son Matthew, to all of whom go our deepest sympathy.

TLTL

Phil Frost

Many readers will be sorry to hear of the death of Phil Frost (Dr P J Frost) on 26 March in South Africa. Phil started the Preliminary Clinical Course at Guy's in January 1951, from school, surrounded, but not daunted by mainly older ex-service students. He quickly made his mark with his irrepressible enthusiasm, his charm and sense of humour and he became a brilliant student and delightful companion. He not only excelled in his work but also played competitive tennis and became Captain of the Guy's team—his peak cap on the tennis court will be remembered by many.

After qualifying Phil specialised in Radiology and returned to South Africa. For many years he was dogged by ill health but continued to work until he was forced to retire, During the last two years he was confined to a wheelchair at home but continued to report on X-ray films.

His wife, Judith, and his daughters, Evelyn and Joanne, gave him enormous support and encouragement and we send them our deepest sympathy.

Patrick Moore
(Guy's 1948-53)

Classifieds and Announcements

The *Gazette* is pleased to publish classified advertisements.These are charged at the rate of 10 pence per word—money with order please. It is helpful if you can include a contact telephone number in case of any queries.

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Waste not, want not

I think we nurses are very wasteful in our use of so many items that are thrown away and not recycled. This has been brought home to me recently whilst I was looking at the packaging and materials used in many of the articles we obtain from CSSD, or DSSD as it should more correctly be called now. A lot of containers and instruments are discarded after one use as this is deemed cheaper than the cost of re-sterilizing. Disposables such as needles, syringes and plastic gallipots are not environmentally friendly and contribute to the overuse of non-renewable energy resources and decline of our planet.

In the recent general election, the Green Party was the only one to take such issues seriously. The Greens didn't get many votes, and they didn't get any seats, I didn't vote for them, and since the election is over, this can hardly be accused of making party political points. However, I do think we should examine more closely our use of equipment.

Gone are the days when nurses learned to prepare for procedures by consulting Miss Houghton's *Aids to Tray and Trolley Setting*, a volume I mentioned in another context last month. Nowadays, if a nurse wants to have things ready for a lumbar puncture, she or he looks on the shelf for a packet marked 'lumbar puncture set—adult'. In former days we had to know the instruments which were required, assemble them together, and then sterilize them in boiling water. Any sterilizing that is done in a ward or department now usually involves the hazard of glutaraldehyde. Apart from instruments needed to carry out any procedure, there are invariably more swabs than strictly needed, and various bits and pieces of unused materials are also thrown out.

I wonder how many readers can remember the days when nurses packed drums of dressings, which went to autoclave? We didn't waste wool and gauze then—it meant more boring sessions of packing too soon! The abundance of these materials encourages waste—and cost to the NHS—even though time is not lost through nurses preparing instruments and wadding themselves. Remember, some of the packing and folding was done by patients—a useful form of occupational therapy?

There also seems to be an excessive use of paper to communicate ideas and messages today. Incidentally, although the *Gazette* may be over-expensively printed, I can assure readers that my original longhand copy is written on the clean back of printed sheets no longer required. (Similarly, we are using old letterheaded paper for proofs—Ed). I hope the 'corporate identity' stationery for Guy's will not mean the destruction of mounds of printed stationery in the name of our 'image'. Have you seen this new stationery? 'Guy's' is printed at the top right hand corner in letters large enough to be read across the width of St Thomas' Street; unfortunately this latter part of the address appears at the bottom of the page and requires the use of a magnifier for even the least presbyopic amongst us. Ditto the telephone number. The use of 'windowed' envelopes is also not advocated by those who are concerned with recycling. Let's hope no-one discovers that the multi-use transit envelopes represent a source of cross-infection in hospitals, as these are one area where

recycling has been in economic employment for many years.

Nurses use a great many containers dispensed by the pharmacy—I now know how this verb came into being; they are dispensed with after use! I have returned containers to the pharmacy, only to be politely informed that they do not need evidence of the use of their contents. Gone are the days when medicine and tablet bottles were coloured and re-used.

One of the reasons often given for throwing away so much is that this is cheaper than paying for the labour and time required for cleaning and sterilization. This may be true, but is it not time that large institutions such as hospitals, and the nurses who work in them, adopted a policy to counter the damage we are causing to this, the one earth which we have to live on? There are groups already set up to conserve energy, but our cooperation in not causing so much waste in the first place is vital. At least this is a subject we should pause to think on.

Denis Cobell

Continuing training for the blind at Guy's

'Describe how you would treat chronic axillary adenities with shortwave. What circumstances might require you to modify your technique?'

'Describe a method of application of the sinusoidal current which might be used for the treatment of poor circulation of the lower limbs.'

These are two questions taken from the papers set for the electrotherapy examinations on 9-10 November 1944 by the Chartered Society of Physiotherapy for blind candidates.

Students from the North London School of Physiotherapy (NLSP) have been gaining some of their clinical experience in respiratory care in Guy's for the past few years. Four students will join us again in June and July. Their training is very different from that in 1944—as indeed is all physiotherapy training. The RNIB has trained physiotherapists in a special environment for more than 50 years, but is about to establish the first

specialist unit for visually impaired physiotherapy students in a mainstream school of physiotherapy.

The first students to join a mainstream school will enter the Polytechnic of East London in October 1992. They will be supported by the RNIB resource unit. This involves a senior lecturer and a technician giving expert advice regarding equipment and facilities in braille, audiotape, large print and computer. Some visually impaired students are already in mainstream schools and are supported by the RNIB without specialist units on site.

The NLSP will close in 1995 when all the present students in the school will have completed their BSc (Hons) Physiotherapy with Human Science degree programme.

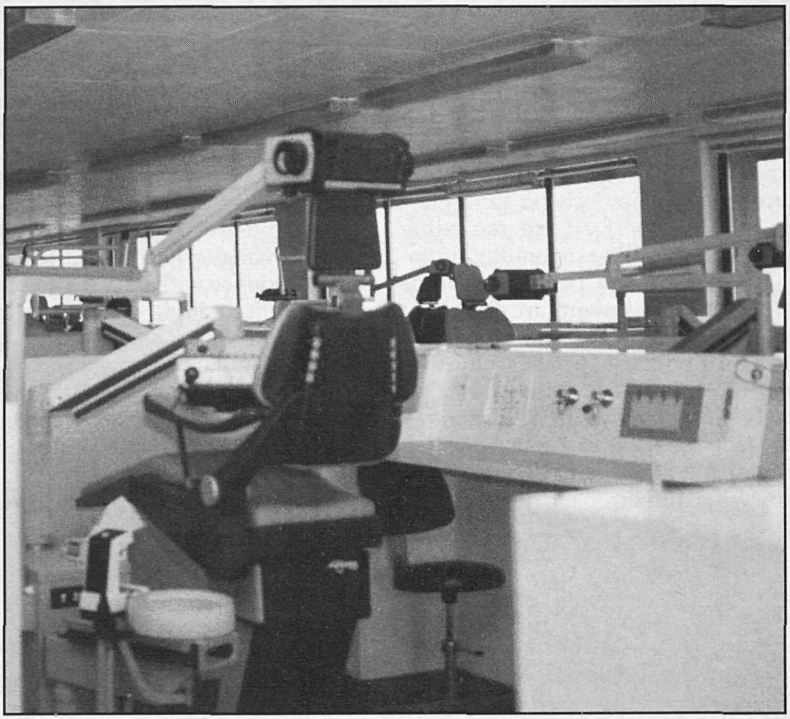
Guy's has had a commitment over many years to employing physiotherapists with a visual handicap both in the clinical service and in the school.

Although we will not have any more Guy's students after their final clinical placements in April/May we will continue to have physiotherapy students on the campus, as the students from Brighton and Kings will continue to gain clinical experience with us. Our commitment to student training will always remain with South East Thames, but should we have any spare placement which are not required by the regional schools we would hope to continue to share our experiences at Guy's with the students from NLSP.

Diana Innocenti

Dental School Clinical Day

Clinical Day in the Dental School was held as usual on the first Saturday in March—7 March this year. As far as I can remember, it has taken place every year without fail since I came here in the 1960s, and of course it has become a well-established tradition by now, but I think that the term 'Clinical Day' has become a misnomer. Although some displays and lectures etc of dental interest are put on, it is not particularly clinically orientated. Its prime function is really as an opportunity for a reunion for former students, staff and others with a connection with Guy's or the Royal Dental School.



Dental equipment demonstrated at the Clinical Day

I must say I enjoy it now, having been here long enough to know generations of former students and a good selection of past and present members of staff. There are always plenty of people to talk to and to catch up on the news with. Attendance has seemed rather on the small side the last couple of years, and it has been suggested that one reason for this may be prevailing economic circumstances, which make it less easy for dentists and others to take time off and travel perhaps considerable distances. I don't regret these smaller attendances—if numbers swell too much certain areas of the Dental school cannot accommodate them comfortably, get congested and worst of all, overheated, as the air circulation system fails to cope.

A wide variety of presentations were put up on floors 21, 22, 23 and 26, showing something of the range of scientific and clinical work that goes on here. Some of it was highly technical, having been ar-

ranged in a specific way for communication at specialized scientific meetings, and I think it must have been quite a challenge for some of our Clinical Day visitors to take it all in and appreciate exactly what it was all about.

The first Clinical Day I attended here, I stood dutifully by my presentation until an elderly practitioner approached me, ignoring the work I was trying to explain to him, and reeled off a list of names he knew. As a staff member, did I know any of them, he asked? I had to confess I didn't know a single one of them, whereupon he told me he had qualified in the 1920s, then spent all his working life in India, and this was his first time back at Guy's for over 40 years. I don't know how old he thought I was but the point was clear—he had retained an image of Guy's in the 1920s in his mind, and the purpose of his return on Clinical Day was purely social, to try to look up some (very) old acquaintances.

On the same theme, one relatively new feature is the OSSA get-together, which I gather is a way in which former students and staff of the Royal Dental Hospital can keep in touch, so you can see that Clinical Day fulfils a valuable role in that direction.

I thought Professor David Poswillo presented a riveting lecture on cases he and his colleagues had seen and treated during his long career in oral surgery. In particular, I don't think any of us will forget some of the patients he showed us from his expeditions to South America. This illustrates part of the appeal of Clinical Day—the opportunity for us and our visitors to learn something of the scope of different disciplines within the Dental School, and how cases referred by dentists in practice are dealt with. The latter may even be in the audience in the hope of hearing how treatment was followed up at Guy's.

One small item that had drawn comment over the years was the lack of any definite lunch arrangements for the majority of the people attending. It was always said that this was because the only lunch most of these would want was a liquid lunch! This year, however, there was a welcome new scheme whereby a ploughman's lunch with wine was available on floor 20 for those buying tickets in the foyer. I can vouch for the high quality of this and the generous portions that were served. Among those who sampled it, the general opinion seemed to be that it should be continued in future years. Others said they would have come too had they known about it, so perhaps this is a pointer to the need for wider advance publicity.

Lastly, I hope our visitors enjoyed the day as much as I did, and that they appreciated all the hard work the staff here put into it. I am sure we all wish to thank the chief organisers on whom the main burden fell, for their efforts in making the day so successful.

Trevor Grenby

Casualty simulation—an aid to training

In past Dental Society lectures, the members have been exposed to a large selection of gruesome reminders of what injuries the human body is capable of sustaining. These have ranged from the horrific portrayals of the fatal injuries

from the Lockerbie and Zeebruggue disasters to the wizardry performed by the oral maxillofacial surgeons when rebuilding a patient's mutilated features. However, in the latter cases, arguably the most critical aspect of the treatment is not necessarily the complicated surgical reconstruction but the basic first aid life saving treatment given to the victim just after the accident has occurred. This simple, but often overlooked, stage of treatment is the most crucial, but yet how many of us health care professionals, are actually confident and competent enough to perform it when called upon to do so?

Dr Colin Dawson qualified as a doctor at Guy's in 1952 and after spending the best part of 40 years as a GP, is now the Senior Medical Adviser to the Casualties Union—an organisation formed in 1942 that is now recognised as the leading authority in producing simulated casualties of a very high standard. Indeed, they are at present being used to train doctors and nurses in advanced trauma life support courses run under the auspices of the Royal College of Surgeons in London, as well as the paramedics of the London Ambulance Service and other first aid organisations.

The evening's presentation took upon a guise not normally experienced by the Dental Society—a practical demonstration. The full auditorium was treated to a varied floor show—an unconscious lady, a broken clavicle, a hand injury, a broken leg and a fractured zygomatic arch to name but a few. All the actors and actresses played their parts with great realism and were aided by the stunningly life-like make up to form the wounds. It's amazing what one can do with some bread, ketchup and old bones these days!

On reflection, the ability of these thespians was a little unnerving to say the least and it says a lot when one of the actors depicting a heart attack victim was taken into an unnamed casualty department (as part of an exercise). Even though the ECG and other tests showed perfectly normal readings, on the strength of his acting alone the staff present were prepared to ply him with the appropriate drugs for his treatment. Needless to say, on seeing the needles being unsheathed, a miraculous recovery was made!

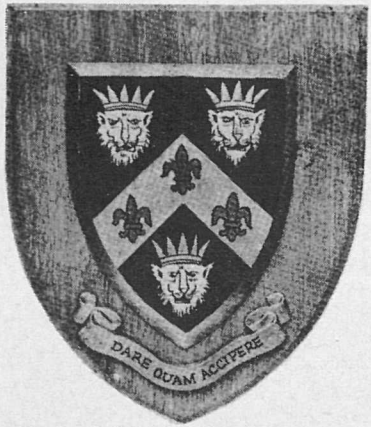
One 'patient' having received a deep laceration across the forehead after a road traffic accident, required treatment involving suturing the wound. Thanks to the excellent make-up this was actually possible, as was demonstrated by Mr Paul Sheppard.

The take home message from the presentation was a very simple one. However well trained one is , everybody must be able to perform basic life-support procedures like maintaining an airway and stopping haemorrhage, without the use of specialist equipment.

Dr Dawson and his helpers put on a very entertaining show, and the Dental Society appreciates all the effort that was put in by them.

Avijit Banerjee

Guy's Hospital Gazette



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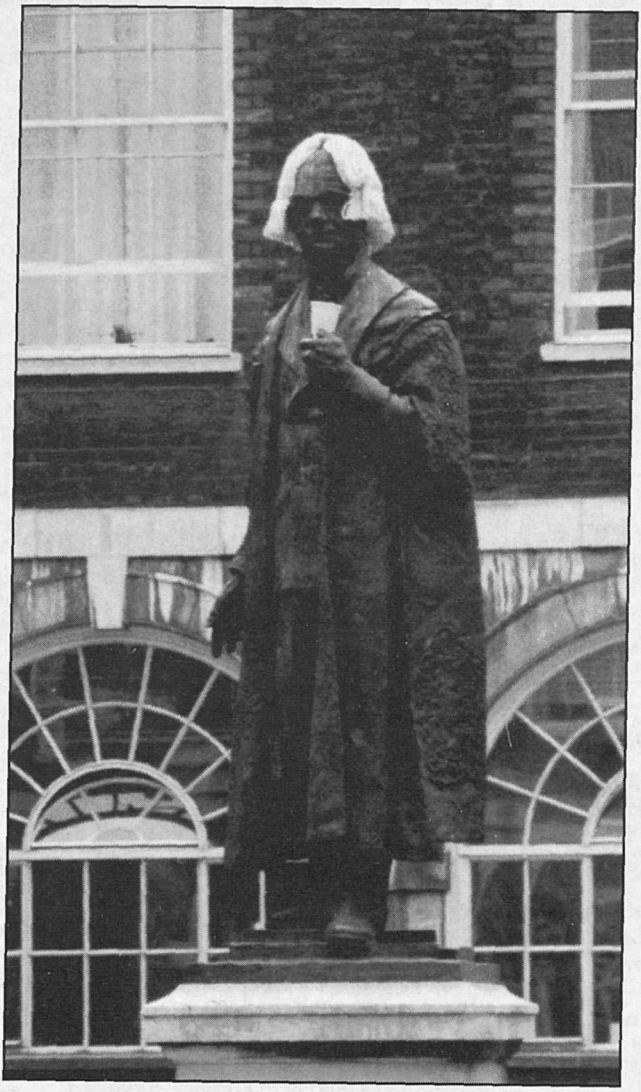

Even Viscount Nuffield can't escape the attentions of rag week

UMDS Mixed Hockey Tour to Lille

Having set out with seven women and eight men from Guy's our first mistake was to leave poor Louise Meredith on the ferry at Calais, never to be seen again. Next to disappear, temporarily, was Ruth Prosser—into the coach toilet. Four more of the team were to disappear for most of Saturday, later blamed entirely on Neil's intestines. This in turn was blamed on Friday night which had started with confusion over directions followed by a confused array of pub crawls, night clubs, and apparently an official dinner and finished in hazy states of confusion in the local bar.

After a Saturday morning and afternoon of enthusiastic supporting, joined by a van-full of wandering kleptomaniacs, cheered on by the mysterious tangerine dreams and a mad Irishman waving a knife—we staggered on to the field of play., Some of us could focus on the opposition who appeared to be the entire Lille University Mens Firsts. Unfortunately the better looking team fell to an 8-1 defeat.

Beaten but definitely not disgraced, the evening was spent enjoying the lavish hospitality, impressive singing and beautiful fountains of the French followed by a nice warm cobby shower.

A memorable time was had by all; our thanks to the Lille students and our apologies of course to Louise, with thanks also to Gordon, the wandering van-full, and a tangerine dream.

Tourists: Simon Moodie, Colin Haywood, Tim Campbell-Smith, Abhi Lall, Andy Russel, Simon Chowdhury, Neil Galletly, Penny Grace, Katy Peace, Ruth Prosser, Jules Matthews, Tania Grace, Emma Bracy, and of course Louise Meredith.

Simon Moodie

Rugby club tour Lille 1992

It was true, incredible, but true! The medical school, not well-known amongst the students for profligatry, was indeed to send a contingent to play Lille Medical School at various sports. Most remarkable of all, that contingent was to include a rugby team. My popularity as Captain soared, which was not difficult; my anxiety as standard-bearer for English rugby abroad also soared when I examined our record. 75 points for and 164 against in seven matches was poor by any standards. Interestingly, despite our one win, I calculated that we had been in the lead for only 10 seconds of our entire season to date, courtesy of a last minute try in an error-strewn victory over UCH andMiddlesex in our deceptively successful opener to the season. Our brief, further to winning the match, was to cement a fledgling relationship between Lille Medical School and our own UMDS. There was speculation as the whether this was part of a long-term strategy to resite the Department of Physiology on the Franco-Belgian border (in the interest of academic excellence) but as senior members of staff were few and far between,

our precise purpose remained unexplained.

Our journey to Lille was mercifully uneventful, but as Friday evening wore on, I grew increasingly concerned that I would not have 15 fit players by Saturday afternoon, as the refreshment which many had enjoyed on the ferry took it's toll.

However, invigorated by several minutes sleep, our 15 leapt enthusiastically onto the coach at 10am to support the football team. A 2-2 draw ensued, followed by a large lunch with free wine. Chanty suggests that I should ascribe the size of this lunch to the generosity of our hosts—and I shall say more of that later—but I had heard several stories, which I had dismissed as apocryphal, of prematch feasting of touring English rugby teams in an attempt to slow them down. The effect in our case was thankfully minimal, except for the fact that two of our players were not so much half-backs as half-cut by the 3.30pm kick off.

To be honest, the UMDS concept has yet to work on the rugby field. Our poor season is not the result of a lack of talent, more the result of a lack of pride in what we represent. In this respect the match against Lille was a watershed. Galvanised by the experience of playing against a foreign side, and therefore to a certain extent representing our island, the side played with spirit and aggression from the start. We were admirably supported by our adoring fans, and despite giving away several pounds per man and aches in the liveout, we dominated the tight to an unprecedented degree. Against a fierce wind we won consistent and effective loose ball, resulting in a fine try by Duncan McAuley after 10 minutes. Lille replied almost immediately due to an unfortunate charge-down of a clearance kick, and using the wind to pin us back they turned around 7 points ahead at half-time.

Our reply was not long in coming. Messrs Tutton and McAuley scored tries within 10 minutes of the restart as we surged into a lead, aided by an excellent touch line conversion by the latter. Lille, to their credit, instilled a new vigour into their game—6 substitutes are apparently the norm in France—but our control of the right and close marking (So that's what close marking means; exam results are based on rugby scores—Ed) in the midfield prevented them from challenging our lead. We finally emerged as winners 28-18, the most satisfying result of my year.

Gallic pride was somewhat restored in the freezing dusk when their men soundly beat our 'mixed' hockey team, the matches thereby ending all-square.

We raced back to the hotel, slipped into something more suitable, and arrived at 8pm at Lille Faculty of Medicine to dine in their equivalent of 'The Spit'. Comparisons favoured the French in every respect. The hospitality was excellent; cocktails as an aperitif, illicit pastis in the pissoirs, abundant vin de table, supplemented by a three course meal. The Lille Dean, who had attended every event, beamed his approbation at every song and national anthem that shook the room, and was even polite enough to pretend to understand Anne Ward's thank you speech in fluent Franglais. Anne, incidentally, did and excellent job as diplomat and tour organiser in difficult circumstances. She should receive the sincere thanks of all concerned.

I dimly remember receiving two cups from Monsieur le Dean, and being invited to drink copiously from each. Our hosts sportingly (and inebriatedly, I suspect) drove us back to Lille town centre in their cars, and the parties continued at several different venues across the city. The Lille students and staff were quite excellent hosts and I only hope that this will be remembered when the return trip is organised this summer.

Tourists: J Thallon (Capt), G Tsolakides, S Russell, K Ivill, A Bates, J Spencer, A Skyrme, M Giles, J Hawker, R Perry, R Breeze, M Tutton, G McLennan, D McAuley, M Lewis.

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Marriage

Anna Edwards (Physiotherapy Department 1978-92)—Professor Jack Fowler, currently Professor of Human Oncology at the University of Wisconsin, USA.

Death

O'FLYNN, William Redmond, died suddenly on 28 April. Consultant surgeon at Guy's and Greenwich District Hospitals. He leaves behind his wife, Doreen, and two sons Richard and David.

A full obituary will be published next month.

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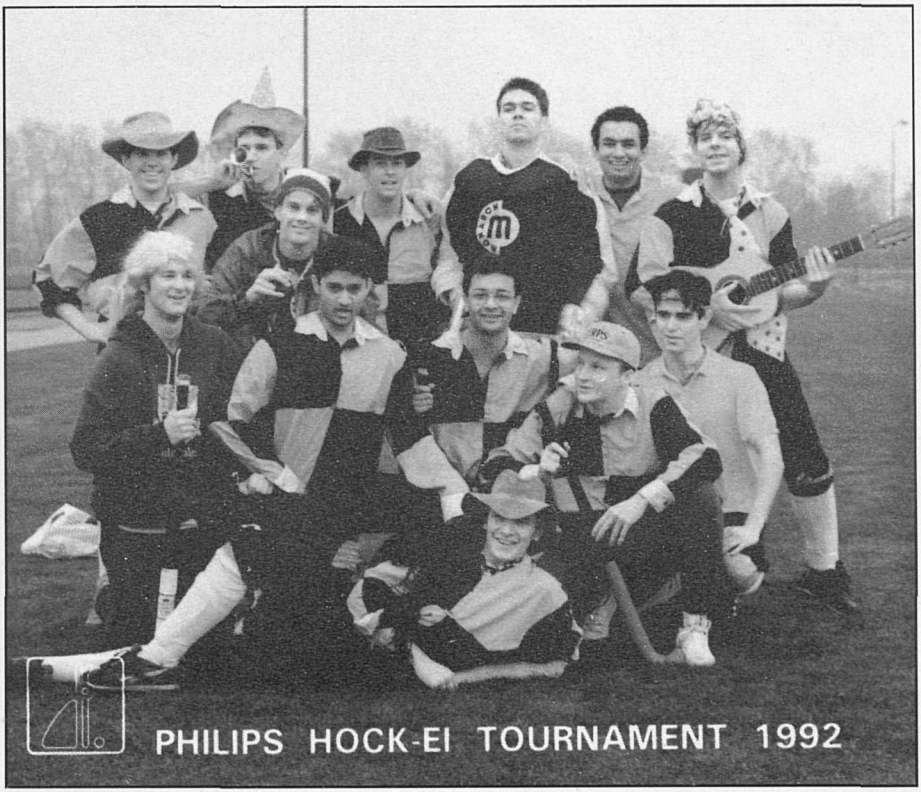

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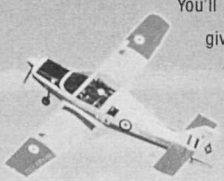

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Guy's Gazette

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Passim

A study published in the *BMJ* of 23 May quantifies the success rate of cardiopulmonary resuscitation (CPR) in a sample of UK hospitals. Sadly, the results are not inspiring. However, should we be surprised, given the lack of emphasis given to this subject during our medical education.

From my own preclinical experience, the only training received was one lecture, which included a video demonstrating the correct technique. The management of cardiac arrest is one of those things that needs to be constantly practised until it becomes second nature, and theory is in no way a substitute for practical training. Why then are the facilities for this so poor at Guy's? Some may say that it does not really matter for preclinical students considering how little time they spend on the wards anyway, and also given that the crash team is only a bleep away. However, in the eyes of the public, once you don a white coat their perception of you changes. You are expected to know things, and behave in certain ways. A white coat will lead to you being asked directions to outpatients, or the dermatology clinic or where to find a friend who's just had a baby boy. These are not life and death matters, but if the patient that you are doing your sixth term case history on has a heart attack, that is an altogether more serious situation. True, it shouldn't take very long for the crash team to get there, but in those circumstances minutes matter.

There really should be no excuse for the lack of facilities at Guy's for resuscitation training for students. This is skill, the teaching of which shouldn't be left to one firm at Greenwich that some people won't do until they have spent five years at Guy's. It should be introduced at the start of the course, and repeated periodically throughout our time here. Hopefully, we will then have a greater level of competence than members of the general public should we happen to witness an arrest outside hospital, and likewise as the on-call houseman we should have a better idea of what to do.

Paeds Dept—always willing to listen

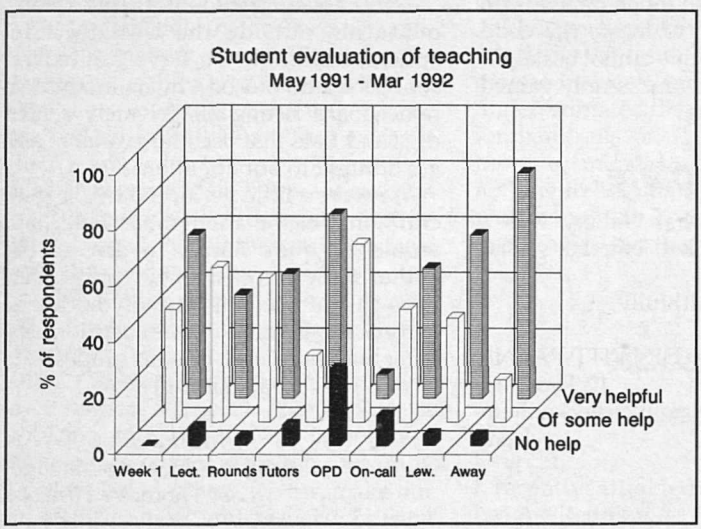
Dear Sir,

In reply to the letter of V P D'Off, published in the April issue of the *Gazette*, we regret that the correspondent felt it necessary to have recourse to such comments. We also regret that the correspondent felt the need to remain anonymous, presumably on account of a mistaken fear of victimization. The value of anonymous letters is, at best, questionable. We commend to the Editor of the *Gazette* the example of those newspapers and journals—the majority—that refuse to publish them. Our main concern, however, is the correspondent's unhappiness with his or her experiences in paediatrics.

Since October 1990, each paediatric student has had the opportunity of evaluating their teaching. We enclose a figure summarizing the feedback from the last three firms. Such student opinion has formed the basis for the recent substantive changes in the teaching of paediatrics. These include:

- An increase in the length of the firm
- An increase in the time spent in general paediatrics at Lewisham or on the away period (from three to four weeks)
- An introductory week of 'core knowledge' lectures
- Smaller numbers in tutorial groups
- New outpatient clinics for the students to attend.

There is an enormous amount of structured teaching during the paediatric quartile. In our experience however, the brightest and best students are those who have made full use of the unstructured time by talking to and playing with the inpatient children. Those who merely visit the wards to clerk a child for the next ward round are those who remain unfulfilled, disillusioned and ignorant of the principles of paediatrics.



Of course there remain problems in the quartile which are highlighted by student evaluation (such as difficulties in outpatients and too many cancelled sessions) and to which we are directing our attention. The students' evaluation over the last year or so (see figure) demonstrates that overall they find

the paediatric teaching useful. We hope that future generations will continue to benefit, and that they will continue to offer constructive criticism, preferably not anonymously.

Yours faithfully,

WILLIAM VAN'T HOFF
PROFESSOR GEORGE HAYCOCK
Division of Paediatrics
UMDS

To be taught, or to learn?

Dear Sir,

V P D'Off's letter (*Gazette*, April 1992) raises some interesting questions. Are students at Guy's there to be taught? Or are they there to learn? The latter is an active process and the former is a passive one. In paediatrics, so much depends on the student's ability to locate the child within themselves—this cannot be taught by any paediatrician and is only gained by dint of experience.

Chocolate

I always thought that Galaxy was a chocolate bar. All luck to 'em; that's what I say.

Yours faithfully,

DR J PITT-PAYNE
12 Top Park
Beckenham
Kent

UMDS accomodation

Dear Sir,

In response to the letter titled 'Accommodation Office' published in last month's edition, I am writing to clarify a few misconceptions concerning accommodation at UMDS.

As is generally appreciated there is an enormous shortage of accommodation here in London and as a result UMDS has been forced to adopt a policy in recent years where hostel rooms are allocated to the following three criteria of student.

Hostel accommodation is guaranteed to all first year and Oxbridge intakes and the remaining rooms are allocated to final year students. If any rooms become vacant or remain empty during term-time, these are filled at the discretion of the Medical School using the most fair means possible.

As for assisting students to find accommodation outside the UMDS hostel sphere, although we have limited resources we do our best by maintaining a noticeboard listing all privately rented digs and flats that become available and are brought to our attention.

We were a little perturbed by the general 'tone' of the anonymous letter and would be quite happy to discuss the author's grievances with him or her. Perhaps in not meeting one of the above criteria for UMDS accommodation, the letter was just a case of 'sour grapes'.

Yours faithfully,

MICHAEL COWAN
Assistant Hostel's Manager
St Thomas's Hospital

Access for the disabled

Dear Sir,
The Trust has been conscious of many complaints received from staff, patients and visitors with all kinds of disability and is working to resolve these. Some are major issues, such as that highlighted in Passim (*Gazette*, February 1992) of the problems of getting from London Bridge Station to Guy's. This will be resolved with the opening of Philip Harris House when there will be a 2nd floor link from the bridge/walkway leading to London Bridge into the hospital itself where, of course, lifts will be available.

A Disablement Working Party was formed in 1990 led by Mike Wooton, the Free Church Chaplain to Guy's who is himself disabled. Staff and patient representatives put forward many areas of concern. One consistent item of complaint was the Colonnade steps. Contrary to Passim's belief, the absence of handrails does make it very difficult for the physically disabled to pull themselves up these steps—something not easy for the able bodied to understand but an issue which is amply borne out by observation. This has been rectified by recent erection of the handrails of which Passim complains. I am sorry that these railings have spoilt the year photograph but I am sure that this will be a small price to pay to make the hospital more suitable for its patients and visitors.

The Disablement Working Party will be continuing its work and looking at problems with all forms of disability—not just ease of access for the physically disabled, but also how we can make our site better for those with visual or hearing impairment. It will be seeking views from all wards and departments; looking at, for instance, the suitability and availability of WCs; and forming plans for implementation of change.

May I, through the courtesy of your columns, ask anybody who knows of, or has a specific problem to contact either Mike Wootton or Theo King in Projects on ext 4506.

Yours faithfully,

SANDRA M CARNALL
Projects Director
Guy's Hospital

Editor's reply

I am very pleased to learn that access from London Bridge Station is to be improved, and that the question of making facilities more amenable to patients, visitors, staff and students(?) is being considered seriously.

The question of the year photograph is not really an issue, and was somewhat tongue-in-cheek. I accept that I may have underestimated the extent of the demand for handrails on the Colonnade steps, however might I suggest that they do nothing to help those people I have seen and helped struggle up the steps with push-chairs and the like?

EDITOR

Appalling nameplates

Dear Sir,
I recently attended the Guy's Nurses League Reunion.

On entering the main gates my friends and I were appalled to see the 'new' blue Guy's nameplates on either side of the gates. They are hideous and quite out of keeping with the lovely wrought iron gates on which they have been mounted. Who is responsible for the design of these nameplates and, in any case, why change the old one?

Yours faithfully,

AUDREY M RANKIN (née CHARLES)
Barnston
Essex

Confidential criticism through SMEC

Dear Sir,

I am writing to you as a concerned member of the student medical representative body. It has recently come to my attention that a number of students from both medical and dental courses are not putting their views forward out of fear of recrimination. In producing an 'alternative' BSc guide for prospective students, a number of contributors disclosed their worry that should they 'speak out' against course tutors they would be in danger of retribution. The result was full anonymity with articles, but even still, they could easily be traced back due to small student groups and so were censored by the contributors themselves. In the last few months a number of dental students also disclosed to me their inability to approach teachers with complaints of unfair biasing towards some students, and raised the possibility of prejudices amongst a number of their demonstrators.

These feelings are not new and have emerged from time to time in the past three years that I have been at Guy's. The implications are widespread but we must concern ourselves with ensuring an adequate feedback mechanism by which students may pass on their complaints to those in charge without fear. The student medical education committee is one such mechanism, and medical students should feel safe in confiding in their representatives. If necessary, the appropriate Deans will be contacted, but students will have guaranteed anonymity. I am unsure of the system available to dental students, but these are clearly areas of concern which need to be addressed.

UMDS has no future if students cannot speak freely, a stage I hope and believe we have not fully reached.

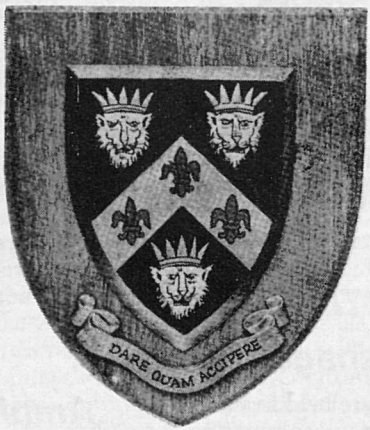
Yours faithfully,

OMAR RAHIM
Chairman of SMEC
Boland House

Computer "Quote"

The library computers behave in a very curious way from time to time. On searching for *Clinical Chemistry—an Illustrated Outline*, two of the closest title matches were: *Gregorian Music 1897* and *Principles of Military Movements 1788*!

Guy's Hospital Gazette



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Physiotherapy School farewell function

A farewell function to mark the closure of Guy's Hospital School of Physiotherapy will be held on Saturday 11 July 1992 in the Robens Suite. Former students and others who would like to attend should contact John Low, School of Physiotherapy on ext 4262.

Question Time for Trust managers

Two public meetings were held in Peckham and Catford last month giving the public an opportunity to air their views about the services provided by the Guy's and Lewisham Trust. Chairman Sir Philip Harris and Trust managers comprised the panel fielding questions over hospital services.

Pre-menopausal workshops

Dr Myra Hunter, a clinical psychologist at Guy's has recently launched a study to determine whether pre-menopausal counselling will help women cope better. 150 women aged over 45 from five south London general practices have joined the study. A control group is being compared with women who attend small group sessions discussing what to expect at the menopause, and how to overcome any problems. Follow up is to be at two months, one and three years.

Confidential counselling

The student counselling service has now started a limited service on the Guy's campus. Counsellors Diana Bass or Paul Pavli will be available for consultation every Thursday from 10am to 3pm in the Small Committee Room office. A booking form is posted outside the door and a convenient free time slot can be ticked. Further information can be obtained from their office at the St Thomas's campus on ext 2410.

Amnifiltration—an earlier alternative to amniocentesis

Dr Dominic Byrne, senior registrar in obstetrics and gynaecology at St Thomas's has been developing a technique for prenatal diagnosis called amnifiltration.

A two-way needle is used to drain out some amniotic fluid which is filtered to remove fetal cells, and then returned to the amniotic cavity via the same needle. Filtering the cells and returning the fluid confers the double advantage of allowing the test to be carried out as early as eight weeks, and providing more cells for analysis.

Research data stolen

Three computers were stolen from the Department of Radiotherapy at St Thomas's Hospital over the Bank Holiday weekend. The computers' hard disks con-

tained data on breast cancer, and encompasses about 15 years work.

This theft serves to underline the vulnerability of data stored on computers, and the importance of keeping regular backups in separate, secure locations. The Academic Computer Unit will be pleased to advise on how best to avoid mishaps such as this.

CPR training

A study conducted by the British Heart Foundation has shown that 70% of patients who were given cardiopulmonary resuscitation (CPR) in hospital died during the initial arrest, and that only 10% were alive one year later. The study was conducted in 12 hospitals in the UK, and reviewed 4,000 patients given CPR.

The British Heart Foundation has decided to pay for some resuscitation training officer posts in an effort to improve cardiac arrest survival rates.

Greenwich computers replaced

A Hospital Information Support System (HISS) has been in place in Greenwich District Hospital since July 1991. Staff at the hospital have greeted it with varying degrees of enthusiasm and disdain. However, less than a year into its running, more powerful central computers have had to be installed to replace the ones originally supplied in order to prevent the sheer volume of information from overwhelming the system. Though several extra months of disruption were caused, the hospital is set to be in a better strategic position. The next stage of the project involves the pathology services, which should be operational from this month.

On a brighter note, at least the replacement machines were provided free of charge by the supplier, HBO of Atlanta, Georgia.

Assault at Guy's

On the weekend of the 30 May, an attempted sexual assault took place. Contrary to media reports, neither the victim nor her assailant were in any way connected with the hospital. It appears that they went from London Bridge Station to an unlocked room on the 2nd floor of the Tower where the incident took place. It is believed that the attacker may be a local man who is familiar with the hospital. A man is currently helping police with their enquiries.

Moves in the medical school

The major project at the medical school is currently the move of the Department of Biochemistry onto the Guy's site, and the migration of the Pharmacology Department to the St Thomas's site.

The move is to be completed over the summer break, in time for the start of the next academic year.

Evian Health Awards

Since 1985 these awards have been presented to reward those who have promoted good health in the UK. The organizers are looking for nominations of

individuals or companies who have made significant contributions to the health of this country.

There are seven categories to choose from:

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- Sport and fitness
- Campaigns
- Environment
- Health writer
- Health broadcaster
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Winning nominations will enter a draw for a pair of tickets to the presentation lunch on 20 October at the Hyatt Carlton Tower Hotel in London.

The awards support Birthright, the mother and baby research arm of the Royal College of Obstetricians and Gynaecologists.

Nominations should include the name of the company/individual, a description of their work, and why you believe they should win an award. These should be sent to Evian Health Awards, Glen House, 125 Old Brompton Road, London SW7 3RP *no later than 10 July 1992.*

Operation Tallin

Operation Tallin is an initiative by the OAEE (Ophthalmic Aid to Eastern Europe). Medical students from Guy's and St Thomas's Hospitals are to transport two Transit van-loads of ophthalmic equipment, including a £10,000 photocoagulator, to Tallin—the capital of Estonia. Books and journals will also be delivered en route to medical schools in Poland, Lithuania, Latvia and Czechoslovakia.

£4,000 needs to be raised by 1 July, and the journey will commence in mid-July to take advantage of the summer vacation and the long days.

Further details can be obtained from Simon Thomson or Naffis Anjarwalla, Operation Tallin, St Thomas's House, St Thomas's Hospital, London SE1 7EH, or by ringing St Thomas's ext 3236.

Classifieds and Announcements

The *Gazette* is pleased to publish classified advertisements. These are charged at the rate of 10 pence per word—money with order please. It is helpful if you can include a contact telephone number in case of any queries.

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Heraldic Tradition—Part of our Heritage

The need for a UMDS crest

It is pleasing to read that the Guy's coat of arms currently displayed on the front cover of the *Gazette* gives some readers so much pleasure. It is with some reluctance, therefore, that I must point out that as a work of heraldry it is both incorrect, and by today's standards, in poor taste.

Heraldic appreciation, it seems, has rarely been strong at Guy's and the matter was first raised—at least in recent times—in 1946, when Kenneth Hooper[1] felt impelled to chastise the Clubs' Union for the use of a poorly contrived Guy's shield incorrectly surmounted by an unadorned helmet as a device for blazers and sportswear. Other than the splendid portrayal over the front gate Dr Hooper was not too pleased either with attempts elsewhere to depict the full Guy's coat. The bad news is that the War Memorial (figure 1), rumoured soon to be restored in The Park after the current battle there has subsided, is singled out in this respect!

That on the *Gazette's* front cover, with it's incorrect helmet, incorporating what appears to be an angry octopus, must be a typical example of over-flamboyant Victorian taste. Dr Hooper would also have criticised the too-elaborate shape of the shield, the poorly positioned figure of Charity in the crest, the excessive mantling and, possibly the angel supporters dressed in garments suggesting that they are about to participate in a judo match. Another example, with the helmet omitted, is shown in figure 2. It is on the remains of a piece of Guy's crockery which emerged some days ago from under the path outside the Wills library. The back is incised with the maker's name, Copeland, which dates it's manufacture to about the middle of the 19th century. The pot was probably thrown in with the hard core when the path was first laid. I wonder if anybody possesses an intact example? The museum does not have one.

Dr Hooper, in his article, included a sketch of what he felt the coat should look like (figure 3) and, with the exception of the helmet, this is close to what it should be. The matter was taken up by H St John Rumsey, MA and his detailed analysis[2] is worth republishing in the *Gazette*. In particular, he explains that only peers are allowed a silver helmet with gold bars and open

visor. Esquires, such as Guy, are awarded a steel helmet with the visor closed. He suggests that the confusion arose because at the time of the award, 1725, (Guy did not have arms in his lifetime) art-work at the College of Arms was at an all-time low and reflected German influence typical of the period. In consequence an Austrian pageant helmet or jousting helmet was mistakenly portrayed in the Guy's coat.

Figure 1. Guy's crest on the War Memorial

Rumsey's concluding recommendation was that the College of Arms should be asked to prepare a new drawing, and was immediately adopted by the Hospital and the following year Rumsey[3] was able to show *Gazette* readers a line drawing taken from the superb new painting by the College of Arms (figure 4). A good copy, in full colour is used as the frontispiece to Guy's Hospital 1725-1948, edited by Hujohn A Ripman for Guy's Hospital Gazette Committee and this would make an excellent substitute for the outdated version currently on the *Gazette* cover.

On a related topic, many will remember that few years ago Guy's Tower entrance hall was graced with a superb rendering of the Guy's coat in a three-dimensional mosaic effect, without question at considerable expense.

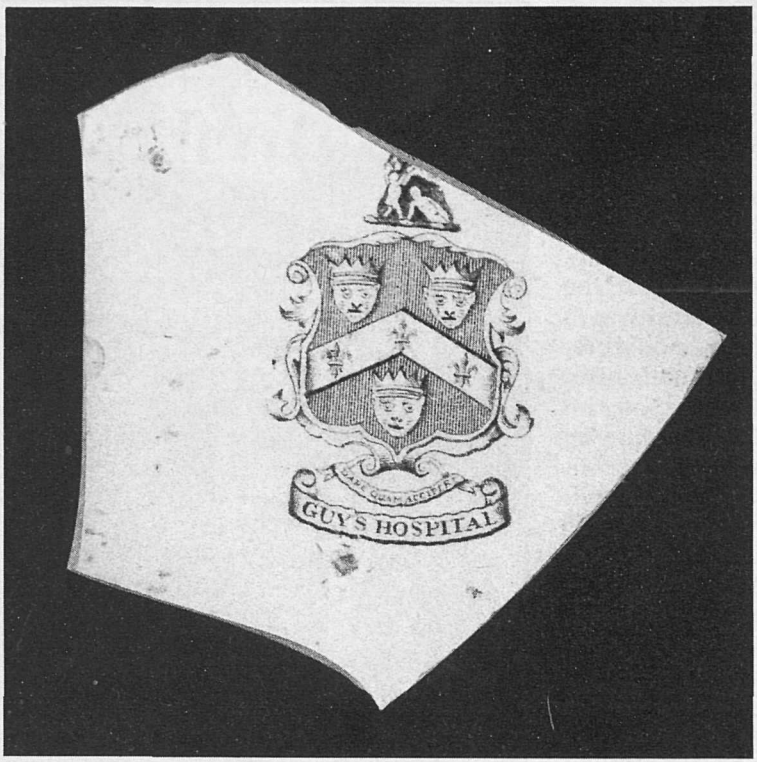

Figure 2. Copeland crockery displaying the Guy's crest

This corner was subsequently converted into a couple of much-needed loos for the disabled and a panel bearing a life-size colour photo of the coat attached to the outside of them. What I would like to know is whether the mosaic is still in place, perhaps to be discovered dramatically at some unspecified date in the future, or whether it has been moved to where it can still be enjoyed if one knows where to find it?

Finally, discussions on Guy's heraldry inevitably turn to the question of why we do not have a UMDS coat of arms, it being illegal to use those of our parent hospitals. I have heard it said that our senior administration claim that it would be a waste of money if we are shortly to amalgamate with King's College. If

Figure 3. Dr Hooper's idea for the Guy's crest

true, this attitude shows a serious lack of understanding of what having a coat of arms is all about, which (unlike the messing about in the Park) is to record for ever in heraldic immutability the historical changes that our institution has undergone. If the formation of UMDS and, of course, the incorporation of The Royal Dental Hospital (which had a coat of it's own) is neglected then it will create an unfillable gap in the heraldic history of Guy's. Indeed, would there be any point in trying to repair the omission after a King's merger? If our institutions have any pride in this matter at all the cost is secondary to establishing our heraldic continuity of change. The hospital coat would not, of course, be affected and the links between Guy's and St Thomas's should be

immediately apparent in the new UMDS one. This is more than can be said for our present notepaper, clever though it is.

D C Watts

1 Hooper K *Gazette* 1946; 197-99
2 Rumsey H St John *Gazette* 1946; 340-43
3 Rumsey H St John *Gazette* 1947; 328-29

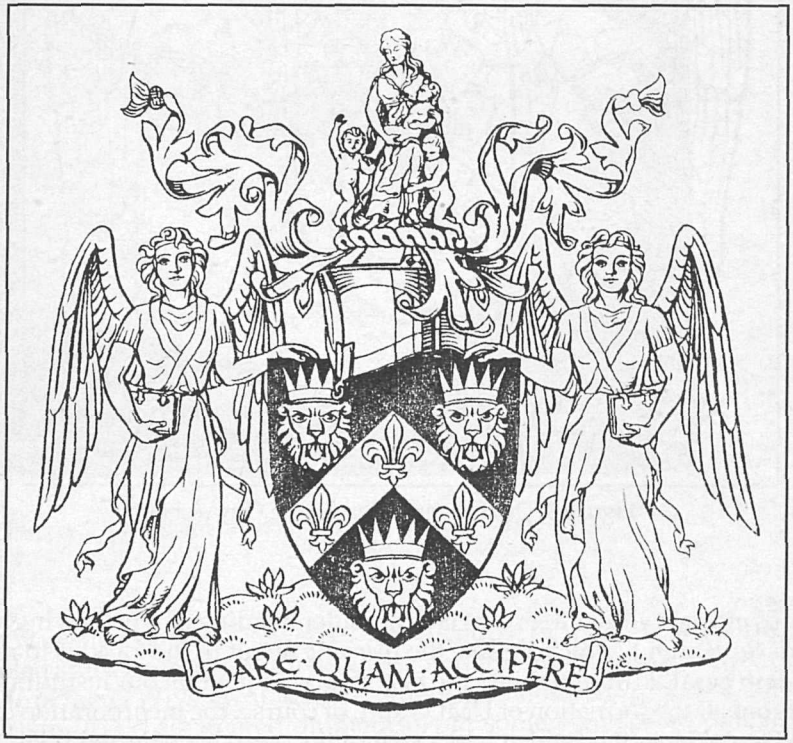

Figure 4. College of Arms redrawing of the Guy's crest

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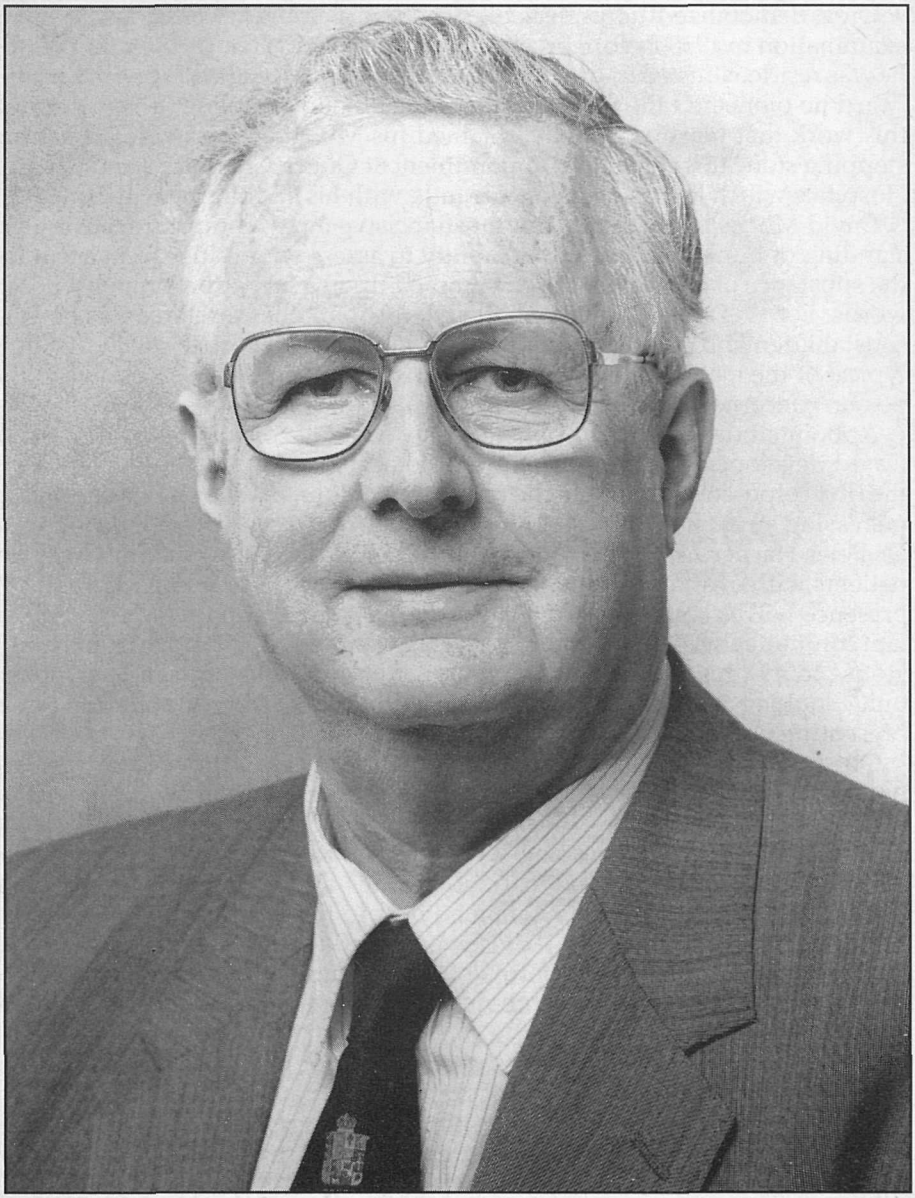
Mr E David Morris

An appreciation

David Morris retired from the staff of Guy's Hospital on 2 May 1992 after 25 years as consultant obstetrician and gynaecologist, latterly as senior member of the department. Already a consultant in Swansea in 1966-67, Mr Morris was invited by Messrs Tom Lewis and John Tomkinson, consultant obstetricians and gynaecologists at Guy's to apply for the post becoming vacant in 1967 on the retirement of Mr Fred Gibberd. He did so, was duly appointed and since that time Guy's has enjoyed the service of one of the most highly respected clinicians in the speciality.

Born and brought up in South Wales, David won a scholarship to Neath Grammar School before completing his studies at Bridgend after the family moved there during the War. From there he obtained a major county award which enabled him to enter the Welsh National School of Medicine in Cardiff. Not content with studying medicine, David Morris enroled simultaneously as a part-time student of music, taking formal voice training. A promising career however came to an abrupt halt when the professors of medicine and surgery witnessed him singing baritone in the *Marriage of Figaro*, and indicated in no uncertain terms that one university degree at a time was the norm! So back to full-time medicine where prizes/gold medals (inter alia in anatomy and obstetrics) followed before qualifying MB, BCh in 1950.

1951-53 saw Mr Morris serving in the RAMC in Ipoh during the Malayan troubles. Being seconded part-time to the Public Civilian Hospital he found himself treating cases of diphtheria, polio and rabies, the latter having been contracted from monkeys and dogs. In the service, venereology (now more euphemistically termed genito-urinary medicine) also featured prominently, and on one occasion he had to administer each of the unit's five cooks a large intra-gluteal injection of penicillin before they could be declared safe to resume normal duties! During this time in Malaya, and armed only with the DRCOG, together with James Wilcocks and John Robertson he covered the civilian obstetric hospital, undertaking the whole gamut of obstetric procedures—including Caesarean section; a world far removed from the refined practise of today with its ultrasound, fetal monitoring, epidurals and neonatal intensive care.



Once demobilized he undertook his surgical training, passing the FRCS examination in 1958, before proceeding to the MRCOG in 1960. From 1962-66 he was resident obstetrician at Queen Charlotte's Hospital where with Richard Beard he pioneered the new concept of fetal blood sampling. It was through this work that he subsequently obtained his MD. It also provided a natural stepping stone to a consultant appointment at Queen Charlotte's and Chelsea Hospitals which he has held concurrently with his appointment at Guy's.

David Morris is a man gifted with an incisive mind, compassionate understanding of human values and an ability to assess with transparent accuracy the substance of colleagues, often summed up in a few appropriately chosen words. For this reason, amongst others, his opinion as a referee has been in constant demand over the years to the benefit of both parties concerned. It is typical of the man that he always made his comments freely accessible to the person concerned so there would be no misunderstanding.

Appointed originally as a generalist (as were all consultants at that time), David developed an interest in gynaecological oncology, setting up at Guy's the first colposcopy clinic. On the retirement of John Blaikley he undertook an increasing amount of cancer surgery. More recently and in conjunction with Dr Peter Harper he ran the joint gynaecological oncology clinic at Guy's for patients with ovarian malignancy and latterly cervical carcinoma as well. His presence will be sorely missed. On the obstetric side he chaired the all important committee set up to commission the Tower Block in the move from Hunt's House to its present site. Subsequently he became 'obstetrician to the renal unit', looking after the many women with pre-existing kidney disorders presenting with proteinuria in pregnancy.

Outside Guy's David Morris had for many years a flourishing private practice, which in spite of the nature of the work, seldom was allowed to impinge on his NHS duties. He has served on the Council of the Royal College of Obstetricians and Gynaecologists as Fellow's Representative. By invitation he became a member of the Gynaecological Visiting Society in 1969 and since 1983 he has been consultant civilian adviser to the Army. Since 1975 he has been the Regional Obstetric Adviser on Confidential Reports in Maternal Mortality, one of the earliest forms of the now much talked about audit. In 1982 he was President of the obstetric and gynaecological section of the Royal Society of Medicine.

David Morris has given to Guy's unstintingly for many years both in terms of professional service and by moral example. His patients, the Guy's obstetric unit and those whom he trained owe him a debt of gratitude and will continue to do so for many years to come. It is a measure of the respect his colleagues

for him that over 200 people attended his retirement dinner on 22 April 1992 at the Royal College of Obstetricians and Gynaecologists.

We wish him and Barbara a healthy and happy retirement.

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A Guide to Success in Medicine

Some timeless pointers for the practice of medicine

Recently, I was sent a small booklet by Miss Brenda Martin, a Guy's SRN from 1937-41. It was the transcript, printed for internal circulation, of a lecture by Sir Alfred Fripp to Guy's medical students in October 1921, entitled the *Art of Living*. Much of what he said is pertinent to the students and practitioners of today, and I felt an abridged account ought to be published in the *Gazette*.

'The Art of Living'

Time was when every medical student had to serve, before he could present himself for examinations, a period as apprentice to a practitioner. There was much to be said in favour of such a regulation. It gave the embryo a chance of acquiring from his seniors the elements of the art to which he had determined to devote his life. But, alas, that stage in his evolution has been crowded out of the modern cirriculum. The demands upon his time while at the hospital, by the many new specialities and the branches of science upon which they are founded, are ever-increasing. Little appetite and less time is left for him to devote to considerations the importance of which will only be fully realized after he has left his *Alma Mater*. Then, 'qualified' in the sciences and with more or less experience of hospital practice, he goes forth into the great world unversed in those arts which every experienced person knows to be at least as important as the subjects in which he has passed the examiners, perhaps without having realized or even having been informed that his profession is expected to practise the Science *and* Art of Medicine.

He soon feels that he wishes his student career had afforded opportunities of learning more of those other attainments which contribute so much to success in practice. He realizes that though the modern 'Dr Fact' has replaced his predecessor 'Dr Tact,' yet the latter had qualities which were of much value to his patients, and he will not have been long in practice before he will meet with cases for the proper conduct of which he will feel that he needs the aid in consultation of a sound all-round clinician of the old school with wide

experience, general acumen and *savoir fair*, rather than of the consultant who relies almost entirely upon those modern methods of investigation which he himself has spent so much time in studying for his examinations. He will come to realize before he has been long in practice that place of the laboratory should be that of servant, not of dictator. Ours is not an *exact science*.

Now it is obvious that any senior who attempts to put his life's experiences at the service of his juniors must recognize that no two individuals meet exactly the same circumstances. Even such as do have approximately the same experiences will attach very different values to them—will view them differently—will draw different inferences from them. Temperament colours our impressions—in some of us the heart more often over-rules the head than in the opinion of others it should—and vice versa! No man is perfect—trees do not grow to the sky—we are only human after all. We all have the defects of our qualities. It is impossible to know what others will think of our efforts. To be sure is impossible, to feel sure is dull, to seem sure is arrogant. There still exist some who are intolerant of a divergent opinion and appear to consider anyone who differs from them as a congenital idiot. But as time goes on there is less and less scope in our profession for dogma and prejudice and more and more justification every day for the mental attitude of 'I wonder?'

About tastes and temperaments it is useless to argue, and therefore it is with considerable diffidence in the presence of some who are senior even to me that I attempt to chat openly to this coterie of young friends about some of those matters upon which there is room for an infinite variety of opinion but which seem to me essential to the study of that greatest of all arts, namely, the Art of Living. It may seem strange, or novel, to you to hear that called the greatest of all arts, yet I submit that the superlative expression will be justified in the mind of anybody who will find the time to study this 'Cinderella' of the arts. Certainly it is the most indispensable to everyone who would make the best of his life, and it is, alas, the most neglected; perhaps that is why 'common sense' remains the rarest of all senses.

It is not many years since it was customary for almost every English-speaking medical school to open each winter session with an introductory address from one of the seniors, and a vast number of these addresses were devoted to an attempt to contribute to our subject of tonight.

I have no hope or intention of saying anything new tonight. You remember the saying—'If only the young man knew or the old man could'. Well, I am the old man trying to help the young man to see life clearly and to see it whole. Trying to help you become happy and successful in that state of life to which you have been called.

Well, to begin with, you have chosen by far the finest of all the callings in

the world today, provided you have felt *called* to medicine; provided, that is, that you have come of your own free will and feel that you really love it. If you have been forced into it, if you do not love it, if your greatest hope is to get rich quick, you will find it a rotten profession and the sooner you get out of it and start again at something else the better, for you will not be happy in it, and you will not be a success if you keep your eyes fixed on money.

Our profession has been called 'a bad gamble' because there are so few plums in it. But it ought not to be considered as a gamble at all, rather as something far higher. It offers you a certainty of living happily, cleanly and usefully and that is what I call 'success'. Unfortunately it is not given to all to make the most of their opportunities. Still more unfortunately there are black sheep in every fold—so you will find sharks in all sorts of disguises, in all walks of life, even in this great and noble profession, as surely as, on the other hand, you will find gentlemen in all classes of society.

But you have chosen a life of hard work. I often doubt whether anyone outside our profession realizes how hard, how continuous, how exacting, how responsible; for all the time we are dealing with questions which are essential to the welfare of others, not only of our patients, but also those who are dependent upon them, and very often with matters of life and death importance. Every *succcessful* practitioner finds he has too much to do. If he takes hold of his job at the right end he will realize the truth of the saying that there's no fun like work. Nothing succeeds like success. If he finds not enough demand for his services he may take it that he is not being successful, and he had better start at once investigating why he is not more wanted. He will almost certainly discover that the explanation lies in some defect in his own conduct. Somebody well said that conduct constitutes three quarters of life.

Of course you realize already that there are some things in life which are beyond all money. Some of these are the love of home, of children, of country; and all the humanities and ideals and all faith, whatever your faith, are others; and all these loves have free play and great power for good in our profession, opportunities for helping—helping lame dogs over stiles—abound, and 'the doctor' grasps them without thought of immediate reward, and the public expects him to, which must be looked upon as an honour. We have yet to hear of a profession so often and so confidently called upon to work for nothing as ours is.

And you have chosen a life which presents many pitfalls—things are not always what they seem. Don't expect gratitude, you will often meet it—but don't expect it. Don't be surprised when lavish thanks and even lavish expenditure, are followed by evasion of the payment of your account. Don't be 'surprised' at anything that happens. It takes all sorts to make a world. As the

cynic said, 'A man *may* be rich although he wears a big diamond ring.'

But you have all made up your minds to join this profession—and I congratulate you upon your decision for it is the finest of all professions and you join it at a wonderfully interesting epoch in its development. Just think what advances have been effected by its self-denying efforts during the past 30, 40, 50 years! Anaesthetics, antiseptics, bacteriology, radium, X-rays, suggestion, the study of the ductless glands—to mention only a few—and all the practice which depends upon their application, what a veritable renaissance—as epoch making as the Renaissance of art in the Middle Ages.

I called it self-denying, because you will not find that any of the really great contributors to this advance 'got anything out of it,' as the saying is; because many have sacrificed their lives in their effort to help humanity; and also because our constant endeavour has been to cut away the ground from under our own feet—to curtail the need for doctors. Can you name any other profession which has forbone to commercialize its discoveries?

This is an instance of altruism we may surely all be proud of—it is so different from the view of us expressed by the ignorant and unsympathetic who abound in all classes of the public. You can generally spot these folk by the aggressive allusions they make to 'professional etiquette.'

There is, of course, a rule of the road in medical practice, and it is always safer to observe the recognized rules of the road. But it is quite easy to show that the rules, or tenets (for the code is mostly unwritten), of professional conduct have been formed for the welfare of the public. For it has long been an axiom in our profession that in any and every case the interests of the patient must always be the first and the chief consideration of the doctor. If it is not opposed to the welfare of the patient you must next consider the interests of your professional brethren, and not until these have been satisfied may you, in the third place, consider your own interests. But I digress—this is another story—a very large and important one—let me return.

What advances have been made in my time! And what advances will be made in the next 30, 40, 50 years that are yours! What an interesting time you will have! Surely for one thing no operating theatre will be complete without an equipment of 'surgical spare parts' in bottles on the shelf—kidneys, brains, liver, blood vessels, and mucous-lined viscera—and a host of other things ready for grafting, in addition to the glands, bones and joints which have already been implanted successfully.

Next month, Sir Alfred Fripp's lecture will continue and discuss the various career choices open, and the temperaments best suited to each.

FFH

The Meaning Of Life?

I gather up my pens and books,
Prepare to end the day,
Through twilight hours and dark-eyed looks,
I know this is the way.

For what is it I have to do
To satisfy ambition?
But to be one of the few
Whose plans come to fruition.

I wonder what our lives are for,
If not for selfish cause?
Should we try to lucubrate,
Have we time to pause?

I believe life more than just
A means towards an end.
Like wind to willow experience must
Ambitions change and bend.

Does life simply enrich the soul,
Allow mankind to grow
Both in number and in mind?
I expect I'll never know.

John S Gilbody

Guy's Hospital Gazette

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The Hip Bone's Connected to the...?

Dr Pitt-Payne's glimpses of orthopaedics of the past

It was 1930 and my mother—Barbara Guise (pronounced Guy's)—was nearing the end of her days at the Alice Ottley School for Girls in Worcester. The youngest of three children; she expressed the wish to be a nurse, and that caused some concern to her parents and her headmistress. In those days, nursing was a vocation—as I would like to think it still is —and any girl who professed a desire to become a nurse was opting for a career of poorly paid, unremitting hard work. Nothing changes, you see. The headmistress, a woman of great sagacity, suggested that time spent at the Wingfield Hospital at Oxford as a nurse would be more than an adequate test of her vocation. Two years of nursing under somewhat medieval conditions would soon sort her out if she had no aptitude for the task. She took a year off at home after leaving school and entered the Wingfield Hospital in 1932.

Almost immediately, she became aware of Mr G R Girdlestone FRCS—GRG as he was universally known to friends and acquaintances. Gaythorne Robert Girdlestone's first encounter with ill-health came after an accident when he, driving a motorcycle, was in a collision with a horse-drawn vehicle. The shaft of this vehicle penetrated his right thorax and it was many months before he recovered. At the outbreak of the Great War he was unfit for military service. He was 33. He'd got his Fellowship after house appointments at St Thomas's Hospital and had already accepted a post at Oswestry with a group of general practitioners.

At the end of the last century Agnes Hunt, herself crippled, began a small convalescent home for sick children in a private house at Baschurch, near Oswestry. Soon after, she became a patient of Sir Robert Jones and out of this arose his association with her in the development of a hospital that is now still known as the Robert Jones and Agnes Hunt Orthopaedic Hospital. Girdlestone became a regular attender at the weekend sessions at Baschurch when Sir Robert Jones came down from Liverpool to see and treat the children, and when Jones was given responsibility for military orthopaedics in 1916, Girdlestone was given charge of the orthopaedic beds at the 3rd Southern General

Hospital at Oxford. With the help of Sir Robert he acquired some wooden buildings in 1917 which were no longer needed at Bristol, and they were re-erected on some ground made available by Magdalen College adjoining what was then 'The Wingfield Convalescent Home' which was already being used as an auxillary orthopaedic military hospital. These buildings became the Oxford Orthopaedic Centre with Captain Girdlestone in charge. The Ministry of Pensions took the centre over from the War Office in 1939 and then decided to close it in 1922 at very short notice. There followed many negotiations with the Ministry and the Disposals Board of the Ministry of Works and their sale to the Wingfield Committee for £4,000 was finally agreed. Girdlestone was largely instrumental in raising this sum and put a lot of his own money into the venture. The hospital then became known as the Wingfield Orthopaedic Hospital with Girdlestone as Honorary Surgeon and Clinical Director, and it was a model orthopaedic scheme covering six counties and serving two million people. The hospital had been transformed and contained 250 beds, and the moving force behind all this was Girdlestone himself.

William Richard Morris, 1st Viscount Nuffield (1877-1963) CBE, PC, DCL, once cherished an ambition to become a medical student but became instead a motor magnate and philanthropist. By 1910, he had manufactured the Morris Oxford motor car and in due course became the Henry Ford of the UK. He was made a baronet in 1929 and entered the House of Lords five years later. Nuffield House bears his name, of course, as do quite a few chairs he endowed at Oxford University. GRG knew William Morris—as he was then—and was yet another of the many medical men responsible for stimulating, maintaining and directing his interest in all things medical which led to his unparalleled donations to medical research. Girdlestone was the first Nuffield Professor of Orthopaedics at Oxford University, a post he held in an honorary capacity from 1937-40.

My mother—never the self-publicist—was not at all keen to be mentioned in this article.

'Couldn't you wait until I was dead before you said anything?' was her reply to my questions about her early life. However, she recalled the old Army huts and a brick building that was taking shape whilst she was there. This became the Wingfield-Morris Hospital. There was much tuberculosis, osteomyelitis and Perthes Disease (George Clement Perthes, 1869-1927, Professor of Surgery at Tübingen, Germany). On one round , GRG was testing the students from Oxford on the differences between 'real' and 'apparent' shortening, and when they couldn't come up with an answer that pleased him, he turned to my mother who was standing to one side and asked her. Happily, she got the answer right.

'I want that nurse in my theatres!' he announced. The Matron was a bit miffed because she'd got another nurse ear-marked for the honour. So it was that my mother served in theatres for six months with the great man.

Wingfield-Morris nurses attended clinics at the Radcliffe once a week. Much attention had to be paid to cleanliness because what was a VD clinic one day was orthopaedic outpatients the next. Ready-made Plaster-of-Paris bandages were not marketed at that time and it was the nurses who had to make up the bandages; tearing strips of gauze from a sheet very precisely, laying them on a table, pouring the Plaster-of-Paris powder onto the bandages and smoothing it along the length of the bandages with their hands and then rolling the bandages up. When not in theatres, the nurses did time in the Plaster Room. There were no electrical gadgets for cutting off plasters in next to no time, just the shears and a lot of elbow grease.

The treatment for osteomyelitis in the thirties at the Wingfield-Morris was one advocated by an American, Winnett-Orr, where the bone cavity once cleared out was filled with petroleum jelly. He came over from the States to see how his regimen was going. There were no antibiotics, of course. There was a young man in respiratory difficulties as a result of poliomyelitis and an iron lung was brought in from the States. As my mother was of an equivalent size to the patient, she was fitted into this brand new device for the purposes of setting up the machine. It is just possible that she may have been the first person in the country ever to enter such a contraption. She cannot remember the outcome of the case.

Open air was considered to be of the essence in the treatment of TB and patients were exposed to the elements in no uncertain manner. Some mornings were so cold that the water for washing the children had frozen in their bowls before the nurses could get to them. Ex-inmates of Epsom College could tell similar stories. However, the patients were well wrapped up with layers of woolies and rugs. Metal hot water bottles were of the sealed type and were recyled after being re-heated in a tank of constantly boiling water. These were placed at the foot and the sides of the bed so that the patients were kept warm. There was never a single case of hypothermia. My mother remembers the day the Prince of Wales (later Edward VIII) came with Sir William Morris (as he was) to open the new building.

Children from London had to be guarded from sunburn and five minutes a day was the most they could stand when they first arrived. This was due to the relative lack of sunshine and light that permeated their abodes.

Girdlestone was a fearless operator and exploration of the spinal cord was a frequent procedure prior to the establishment of a neurosurgical unit at the Radcliffe Infirmary in 1938. He was not a temperamental man in theatres but

if he thought a student's attention was wandering, the luckless fellow would find he'd had a pair of forceps thrown at him!

At the end of her two years at the Wingfield-Morris Hospital, my mother took first place and first prize in the exams and then applied to Guy's and St Thomas's for a place. In the sixties, and maybe before, there was a saying—and it was the nurses who told me this: Bart's was for tarts, Guy's to get married and Tommies to be a nurse. It was only Guy's that gave my mother a second nursing home and I'm very glad it did—for obvious reasons!

Constantine Lambrinudi was orthopaedic surgeon at Guy's from 1928-43 when he died. A year after his appointment, he suffered a coronary thrombosis which left him with pain and breathlessness for the rest of his life. My father told me once that he'd seen Lambrinudi operating upon a knee whilst smoking a cigarette at the same time. I wondered if such a thing were possible in the pre-War Guy's theatres what with open ether anaesthetics still being the order of the day?

I was on Mr Batchelor's firm and I remember him as a tall, military-looking gentleman with a moustache and a tendency to square his shoulders as though bracing himself. There was a day in theatres when he did a Charnley total hip joint replacement under the guidance of the senior registrar, S C Gallannaugh. The total hip joint replacement was the brainchild of Sir John Charnley and those who had been to his hip unit at Wigan were spreading the word and teaching the operation in the late sixties. This was the first time I'd seen the 'master' being taught by his 'pupil' and it was a measure of Batch's humility that he was happy enough to learn with his firm watching.

Sir John Charnley came to Guy's in 1969 to give a lunchtime lecture and it was a privilege to have seen a man so completely devoted to the hip joint. Like Prof Hunt and 'Tomki', he drove an Aston Martin—a red one. But then the forecourt of the sixties was always crammed with pretty expensive cars. Prior to hip joint surgery and its subsequent perfection, a fractured neck of femur was very bad news for the elderly and here was a development taking place before our very eyes that has never looked back since its inception.

Girdlestone's Operation (removal of the head and neck of the femur) held sway for a long time. I did have one patient who'd had it done in 1950 for TB. She is still alive and into her nineties now. I remember the lurching gait and her capacity to carry a cup of tea whilst she made her way forwards. Whenever I went to see her she always made me scones for tea—a plateful—and there was cream and strawberry jam. Failure to clear the plate was tantamount to an insult and two cups of tea was the norm. One Saturday afternoon, her husband got some chest pain. I lugged a Cambridge Transrite-5 ECG machine along and duly wired him up as he watched the horse-racing on TV. I was all

set to start the thing up when he stirred and said: 'Excuse me doc, but would you mind if I rang my bookie?'

It was a somewhat inward sigh I gave as I unplugged everything so he could get to the phone to place his bet. In the event, the horse didn't win and the ECG was normal.

In 1971, my father had a laminectomy with the late Adrian Henry. In the adjacent room was Professor de Nevasquez (always Dr Never-Squeeze in Residents' Plays) and there was a third doctor on the other side. At 12 noon each day they met for sherry in the room of whoever was most horizontal. Professor de Nevasquez told the story of how he and Professor Keith Simpson had once—whilst in their respective cups—injected 50ml of air into each other's ante-cubital viens. The purpose of this madness was evident—for they both lived.

The modern day management of a fractured neck of femur is indeed dramatic and only recently a lady had her head and neck of femur excised for such a fracture, and replaced with a prosthesis. On my post-operative visit to the bedside it afforded me some pleasure and not a little amusement to ask how it felt to have a 'Monk's' prosthesis inside her. Fortunately for me, she still had a sense of humour—and went home on the seventh post-operative day.

J H Pitt-Payne

1 John Wright & Sons Ltd.*Great Teachers of Surgery in the Past*, Bristol; 1969:54-59
2 Cameron H C. *Mr Guy's Hospital 1726-1948*. First published 1954

Medicine

Churchill's Pocketbook of Medicine. Peter C Hayes and Thomas W MacKay. Published by Churchill Livingstone. Price £12.95

This pocket book has been produced as an 'essential, on-the-ward reference for the student and doctor'. Its publication has clearly been motivated by the success of the *Oxford Handbook of Clinical Medicine*, by Hope and Longmore, to which it is a direct competitor. Doctors Hayes and MacKay and their publisher are to be commended for their enterprise in attempting to challenge what is clearly a very well-established market leader. It is just such an attitude that has revolutionized the choice of medical textbooks in the past five years, so that where once there was the dull and overpriced Davidson and little else, there are now the beautifully illustrated and very good-value Kumar and Clarke, and Souhami and Moxham. Sadly, Hayes and MacKay have not produced a winner in the same way.

For medical students studying for finals, this book should carry a health warning: 'may make you fail'.

For medical students studying for finals, this book should carry a health warning: 'may make you fail'. This is because, although students are mercifully not expected to be word perfect on the management of most disorders in finals, the one they are expected to know in detail is cardiac arrest. The advice given on this subject by Hayes and MacKay can only be described as extraordinary. Nowhere will the reader come across the words 'airway', 'breathing' or 'circulation'. The first therapeutic manoeuvre mentioned after cardiac massage and artificial respiration is the administration of 100ml of 8.4% bicarbonate, followed by defibrillation with '200 or 400J'. Practolol, phenytoin and bretyllium are all suggested before adrenaline, which is only mentioned as an intracardiac injection. In cases of EMD it is suggested that calcium is given first and then attempts are made to rule out cardiac tamponade (but not tension pneumothorax or hypovolaemia). For asystole the authors suggest giving half the dose of adrenaline recommended by the UK Resuscitation Council. Even if all of the above is the standard practice in the authors' hospital it seems remarkable that they have published it without even mentioning the marked discrepancies between their recommendations and those of the Council.

Once page 310 has been ripped out and burnt, how does the rest of *Churchill's Pocketbook of Medicine* compare with Hope and Longmore? It is nicely illustrated throughout, with two-colour diagrams and tables, and is considerably slimmer by virtue of having been printed on both sides of the paper. I find the layout more confusing however, because no attempt has been made to start important new topics on a fresh page—in some cases the heading even appears at the foot of one page and the text at the top of the next. This has doubtless been done to help keep

the extent and therefore the cost down, but it does have severe limitations in terms of readability. The text itself seems to offer more in the way of background information than its competitor, perhaps making it more suitable for the student. It also contains a helpful section on the major side effects and interactions of commonly used drugs.

In conclusion, there is much that is attractive in this, the first real competitor to Hope and Longmore. My confidence in it, however, was irredeemably shattered by that fatal page 310.

M G Slade
HO in Surgery

Physiology

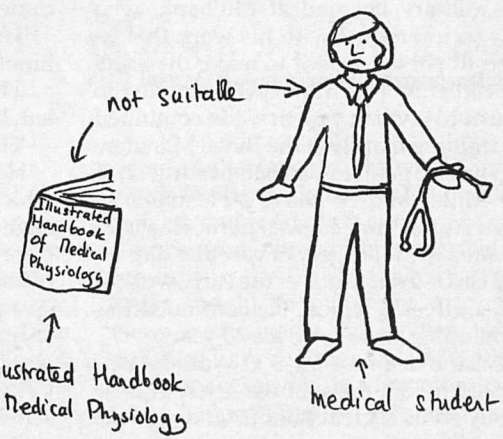
Illustrated Handbook of Medical Physiology. C T Kirkpatrick. Published by Wiley. Price £24.95

Illustrations can undoubtedly illuminate difficult concepts and present information in a way which aids both understanding and memory. Unfortunately in this book too often the question seems to have been 'what can I draw to accompany this paragraph?' leading to a book with too many unnecessary pictures. For example the statement 'They (gallstones) can cause pain, particularly after fatty meals when the gall bladder contracts' is easily understood, the student does not need a picture of a person at the dinner table grimacing. Even so the artist often lacks confidence in his representational powers and the pictures are heavily annotated, thus the gallstone sufferer is not eating sausages and chips but has an empty plate labelled 'fatty meal' in front of him.

The aim is to achieve a broad understanding of principles. It may succeed but at a low level considering the size of the book (548 pages). Throughout the book there is little quantification, thus oxygen dissociation curves are presented without figures on the axes. For a medical student this is a serious deficit. He needs to quantify this relationship if his understanding of real patients is to be anything other than superficial. Graphical material is very sparse and incomplete—on a diagram illustrating the cardiac cycle the atrial pressure curve disappears mysteriously during ventricular systole.

It is not clear from the preface who the textbook is aimed at. It would not be adequate for medical students.

J Ward
Lecturer in Physiology



William Redmond O'Flynn

Generations of Guy's people will be saddened to hear of the death of William Redmond O'Flynn, suddenly on 28 April, and so poignantly within days of his retirement.

Born into a family with a long tradition in general practice in County Limerick, he embarked on his medical training in 1945 at University College Dublin and qualified in 1950. Whilst at college, he was attracted to surgery and decided to make this his career and became a Fellow of the Royal College of Surgeons of England in 1954. Because he wished to live and work in England he decided that he must do 'national service'. Being an Irish subject he was not obliged to do this and he could have avoided it easily. He served in the RAMC from 1956-58 and reached the rank of Major. Most of this time was spent in Gibraltar where he was the senior surgical specialist. Whilst here he came to the notice of Lieutenant General Alexander Drummond, the then Commandant of the military hospital at Millbank, who was so impressed with his work that he tried to persuade him to make the army his career. O'Flynn however, decided to return to civilian practice. He continued his training mainly at the Royal Marsden, and was appointed consultant surgeon to the Miller and St Olave's Hospitals in 1964. At this time he was particularly interested in the surgery of vascular disease and carried out much of the early work in the south east region. He continued this demanding work for over 20 years.

On the death of Mr S H Wass he was invited to join the staff of Guy's. This he regarded as a great honour and was the result of the reputation he had established for his exceptionally fine clinical judgement, prodigious work and teaching. At Guy's he became a popular figure throughout the hospital where his devotion to patients, inspired teaching and concern for the welfare of his juniors was always evident.

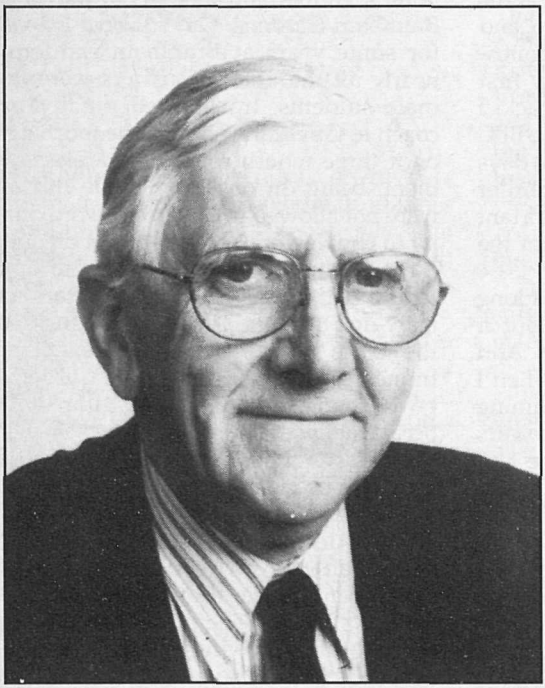
He had an extraordinary breadth of knowledge extending well beyond the bounds of medicine to literature, history, art and music. This wide interest in human endeavour, coupled with his natural kindness made him unusually understanding of his patients' problems and supportive of their needs. The same magnanimity was extended to all his colleagues irrespective of rank. He was genuinely concerned with others' problems and always did whatever he could to help. Even if he was unable to help directly, his understanding and sympathy lightened their load. By his juniors particularly, he was regarded as a friend and confidant who was available at all times for advice or support. It was a tribute to him that at his recent retirement dinner, so many of his former registrars came from far and wide to be there.

Two summed up their feelings about him:

'He never talked to you like a consultant, but a friend.'

'He was a registrar's surgeon.'

He had a marvellous sense of humour which together with his extensive knowledge of literature was a formidable combination. Never used maliciously it could, when required, be used with incisive precision. Above all, it enabled him to maintain a balanced, cheerful outlook on life which was the basis of his popularity. These attributes, together with his self-effacing modesty, engendered feel-



ings of great affection and respect amongst all who knew him.

The suddenness of his death has left a tremendous void in the lives of his many friends. In trying to fill this, they will know that for them life will never be the same again.

Known to all as Red, he was a loyal colleague and faithful friend and will be sadly missed. To his devoted wife Doreen and sons Richard and David, both doctors, we send our deepest sympathy.

I McC and JH

Thirty years on

The Nurses' Ball is an event of some pleasure in the Guy's calendar each summer. Held usually at the Grosvenor House Hotel it takes weeks of preparation on the part of Beryl and colleagues in Nursing Administration to get the right nurses and their partners at the appropriate tables. A high point before the event is for female nurses to visit wards, in their pretty frocks, to the delight and envy of their patients and other staff.

Each year a brochure is published to accompany the evening. This year Lee Soden sought 'to feature an article with views from one of the longest serving nurses at Guy's'. Sister Cole exceeds my longevity of service by a few months. But I was 'volunteered' for the task, to give

my 'personal views as to how Guy's has changed' since my commencement at the hospital. This was over 30 years ago, and I offer an expanded version of my contribution to the brochure. In fact my first memory of Guy's dates further back. I used to hear the sports results on the BBC Home Service when a child. In those days Guy's Hospital possessed a premier Rugby team. I wonder, is it still important in this arena? Perhaps a voice from the sub-continent will let us know.

To remain at Guy's 30 years is a long stretch—even criminals get less! But it hasn't been as bad as that really. And there have been a few changes. When I joined Guy's we had a matron running things on the nursing side; over the years there has been a difference in title and role, but now we have come full circle and the present Director of Nursing for the Guy's and Lewisham Trust is not averse to the title of Matron.

At that time nurses worked 44 hours a week; only a little earlier when I was in training at St Elsewhere, this had been shortened from 48. Indeed, night duty often consisted of 8pm-8am for an alternating five nights on with two off, over a period of twelve weeks.

The dining rooms were divided on strictly hierarchical grounds: student nurses used the large dining room in the Henrietta Raphael Nurses' Home, staff nurses had one half of the rear dining room and sisters the other half. Senior sisters even had their own designated places at table, complete with personal napkins and rings. Woe betide anyone who sat in 'their' place!

Guy's then possessed several off-site nurses' homes, each with Home Sister in charge. The PTS (Preliminary Training School) and residence was at Redhill in Surrey, and there were night nurses homes: Hilton House in Bayswater, and Bramham Gardens, Earl's Court. I lived for some years at Bramham Gardens; nearly all the other occupants were female students, transported nightly by coach to Guy's and back in the morning, on a three month rota. So I rarely saw them, being on day duty. Male nurses were not allowed to live in close proximity to females, and therefore kept off site. If not, we might see young nurses flitting to the bathroom in the then notorious baby-doll nighties! The permissiveness of the sixties was still to dawn. A few other trained staff lived at Bramham Gardens. I well remember one sister tutor, who occasionally drove me to Guy's in her baby Austin, who had a hot water bottle put in her bed, winter and summer, by the resident Spanish maids.

The Queen opened New Guy's House shortly after my arrival, but there were still patients in wards on the upper floors of Guy's House. The present East Wing was rebuilt, following earlier war damage, and opened by the Queen Mother in 1964. The whole site of the Tower was an ash covered car park, though few nurses owned a car at the time. Some things haven't changed much: Hunt's House, the Nursing and Medical Schools, and the Nurses' Home.

And of course, the *raison d'être* for training as nurses were always very much in evidence thoughout the hospital—the patients.

Denis Cobell

Closing stages of the School of Physiotherapy

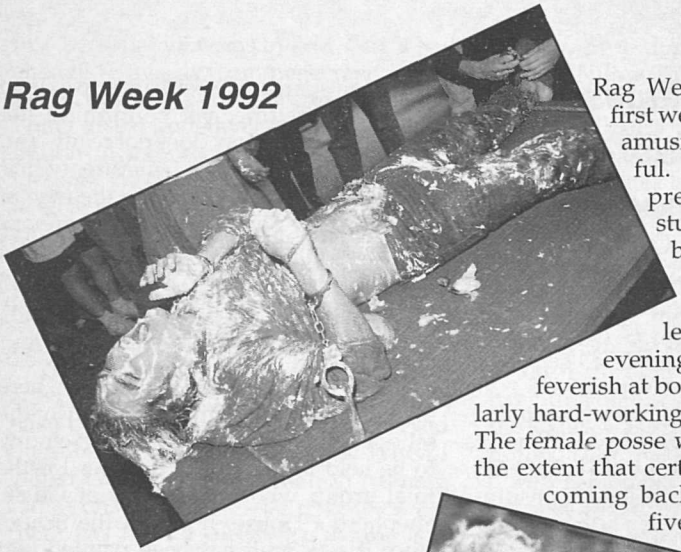
Institutions are often endowed with a life of their own giving them human qualities and frailties. This seems especially so in Britain where tradition is revered and conservatism (with a small 'c') seems to ride roughshod over reason.

Perhaps it is a spin-off from attitudes encouraged by the great institutions of state such as the Monarchy or Parliament. In any case it allows quite modest institutions to be deemed to have human qualities like being fusty or friendly. How many students have said when they first arrive 'I came to Guy's because it was a friendly place?' Others might consider institutions to be sombrous, smniferous, successful or whatever, all really transferred epithets conferring the qualities of the people involved to the place. What makes institutions 'live' is, of course, activity; the nature of the activity, the people, the site, may all change but the continuity of activity is recognised as the 'life' of the institution; it continues as a sort of abstract entity—the old school, the department, the old firm, the hospital, whatever—through time. It is entirely reasonable to equate cessation of all activity with the death of the organism. Regrettably, this, seems the only way to describe what will happen to Guy's Hospital School of Physiotherapy later this Summer. The activity started to diminish in quantity, but not in quality, some two years ago when no new cohort of students was admitted; the final cohort, ever, finishes the course this July completing about 79 years of continuous activity. This time span may seem appropriate to a human lifetime, yet continuing the metaphor in this way does not really suit. Institutions do not grow, mature, wither and die like the rest of us; in the case of the School of Physiotherapy a more apt metaphor might be to say that the School was cut off in its prime, abrupt mortality not being, in this instance, the consequence of prolonged morbidity.

A farewell function to mark this closure is to be held in July, noted elsewhere in this *Gazette*. The ultimate activity of the school will be the Graduation Ceremony to be held at the end of October for the final group who will qualify at Guy's. Shepherd's House, home to the School since it was built has been painted and scrubbed clean on the outside. (Scaffolding up, paint windows, scaffolding down, short pause, scaffolding up again,plastic sheeting sealed over windows, longer pause while occupants become overheated and oppressed by claustrophobic atmosphere, screaming sandblaster starts intermittant assault, occupants still oppressed but now deafened and dusted with it, turgid river of unattractive brown mud appears outside loo where sandblaster finally found an uncovered hole!) The front of the building has now been exposed to reveal its original pretty red and white clean complexion. It really does look very much more attractive without the coat of black grime. The Physiotherapy School is grateful that after seventy years of occupation Shepherd's House has finally had its face washed in time for the last seventy days!

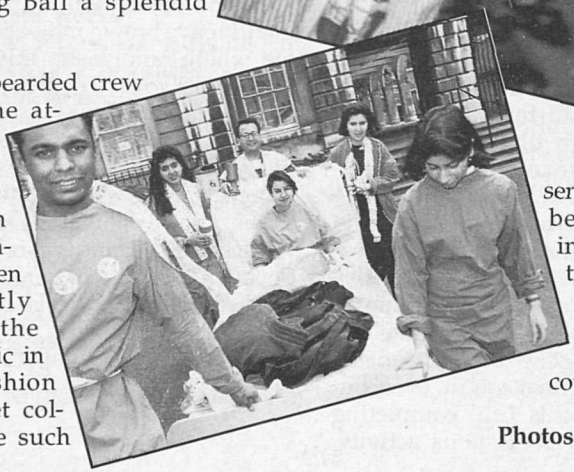
John Low
School of Physiotherapy

Rag Week 1992



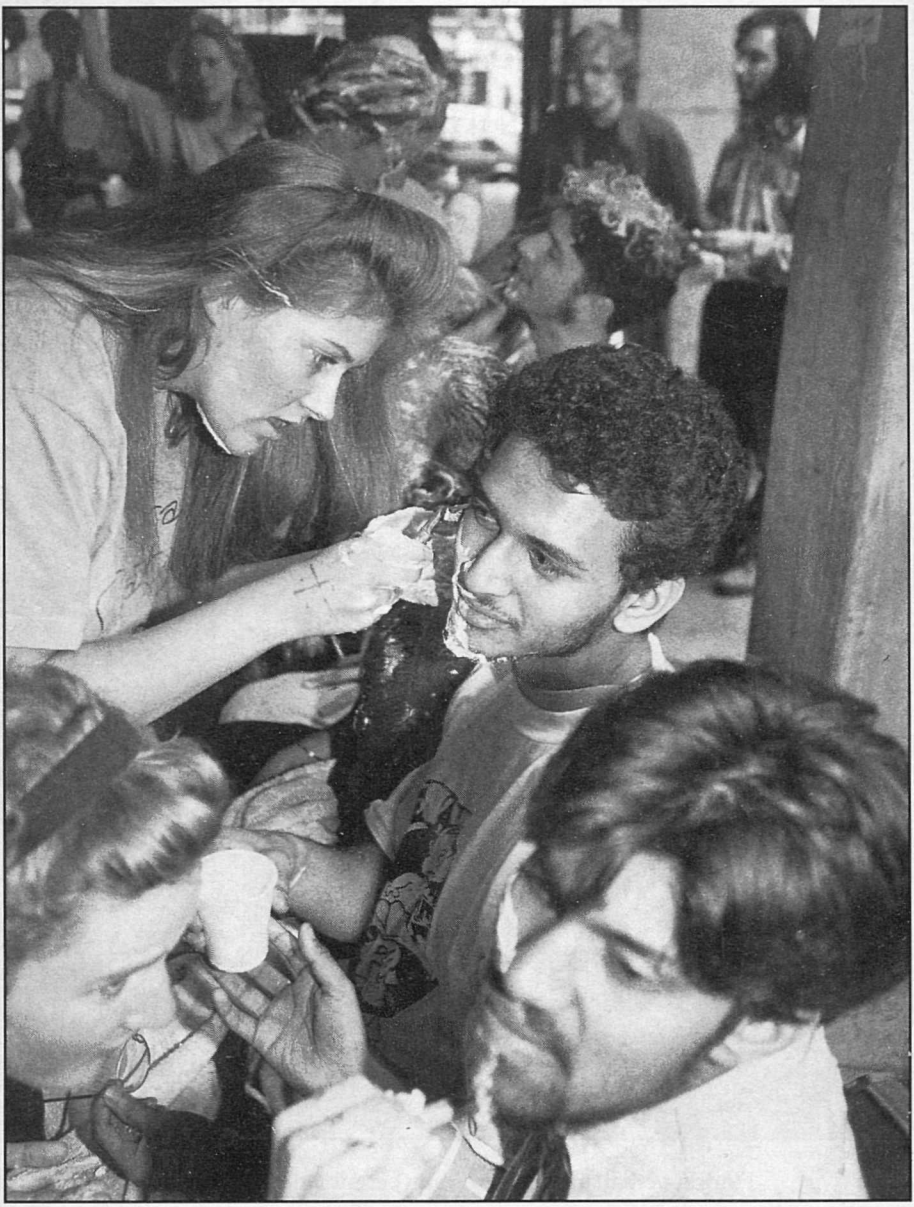
Rag Week took place in the first week in May and was as amusing as it was successful. The response of the preclinical and clinical students was excellent, both organisationally and when it came to participating in collections, daytime and evening events. Activity was feverish at both campuses. Particularly hard-working were the hit squads. The female posse were very popular, to the extent that certain individuals were coming back freshly showered, fiver in hand requesting a re-hit!

The exact amount raised has not been calculated yet as some money is still coming in, however an estimate of £35,000 carries favourable odds at the bookies, so we're told. Among the most successful money-spinners were the hit-squads, the real ale night and T-shirt sales. The cartoon auction raised £1,200 and the Rag Ball a splendid £8,500!



The half-bearded crew added to the atmosphere, organising a public shave-in in the Colonnade and then subsequently harassing the general public in piratical fashion during street collections. One such scalp was the present Home Secretary, being brow-beaten into making a donation at a pub in St Catherine's dock —allegedly £2.00 was all he could muster!

Tom Brink
Photos by Mohjir Baloch



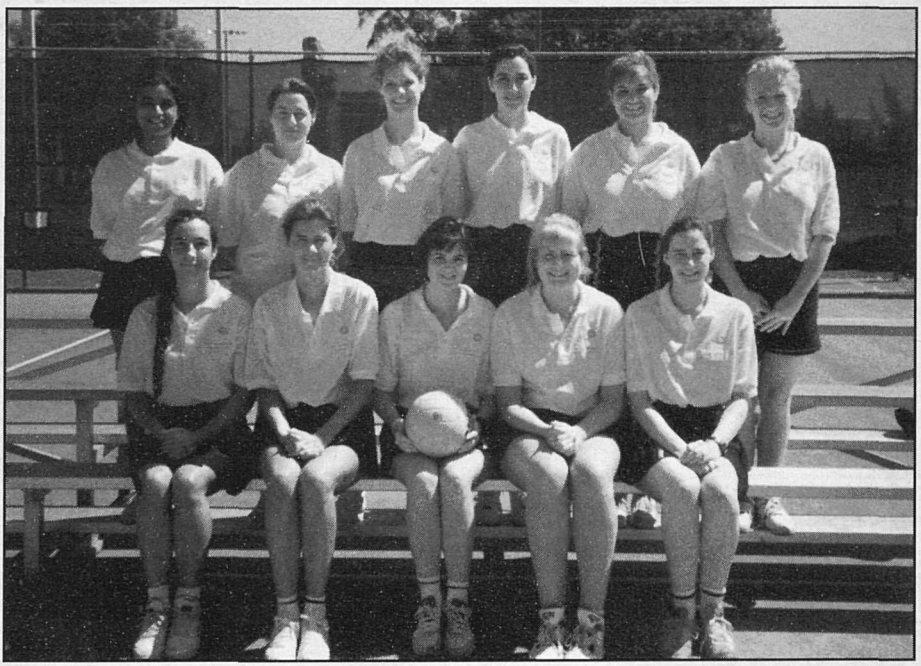
UMDS Netball Tour Florida 1992

Once again, Guy's and St Thomas's Netball Club excelled themselves on the touring front by arranging a tour to Miami, Florida. This was only possible through an enormous amount of fund-raising, including sponsored events and cake stalls!

We arrived at Miami International Airport on 1 March ready to teach the Floridians the meaning of Netball! After a day of Mel's rigorous training schedule on South Miami Beach, we set off to play our first match. This was against 'The Islanders'—1991 Florida Champions. After a slow start due to the humidity of the night and the size of the opposition (!), the jet-lagged, but slowly acclimatizing players began their onslaught. By the 4th quarter, we were goals ahead and playing well, when Iddi, with a Miami Vice-style tumble, damaged her ankle and had to leave the court. However, after a quick reshuffle (bad luck, Kate!), we stormed through the game, winning 21-16.

Next stop was Orlando, where compulsory visits to Wet 'n' Wild, Universal Studios and Disneyland were on the agenda. A good time was had by all!

Several days later, the Florida Champs were off to Fort Lauderdale in search of the sun, complete with Mickey Mouse



Florida netball tourists—the sun certainly shines on some

ears and tacky T-shirts. Here the team had a chance to unwind, with the help of a little liquid refreshment, knowing that all that was in store for us the next day was more of Mel's training sessions by the pool! Luckily for us, an American football team from New York were staying at the same hotel, making training more enjoyable (for some more than others!).

We then returned to Miami for the highlight of our tour—a tournament including seven other teams from various parts of Florida. Despite the fact that we lost several players due to injury, and were playing in temperatures of 95 degrees fahrenheit, we did extremely well to come third (congratulations to everyone for surviving that!). The day concluded with delicious refreshments, typical of the hospitality provided by the American players during the week. We are proud to say that we have been invited back to participate in a similar tournament in November, and are hoping for a visit from the Americans in the near future.

A special thanks must go to our sponsors, Eurodollar, Rent-a-car, MDU, and the MPS, who made our tour possible and such a roaring success. We are left now, looking forward in anticipation to next year's tour venue!

Touring squad: Nicola McDonald, Kate Scanlan, Katie Powell, Melanie Buck, Iddi Bickell, Lisa Dinley, Sally Sheffield, Roops Dhillon, Caroline Payne, Chrissi Cope, Sally Feldmar.

Netball winners

The UMDS Netball team has had a recent triumph. They were the winners of the inter-hospital tournament held at Honour Oak Park on 16 May. The UMDS team defeated University College to win. A full report of the tournament will follow.

UMDS Ladies Football Team

The UMDS Ladies Football Team goes from strength to strength. Established in January we now have a full team of enthusiastic players. After only six weeks of training from scratch we took on St George's. With Juliette in goal confidently directing them, the defence threw themselves wholeheartedly into the game—often at the opposition too! With some ferocious tackling in midfield, and the style and finesse of the strikers, we managed to hold the score at 1-0 (we lost!).

Our initiation over, we then took on Hammersmith, playing on astroturf, and very promisingly won with a score of 3-1. Things were indeed looking up.

Why not come and join us for the next season, starting in October, when we will be playing in the 2nd division of the UL League. All that's really needed is plenty of enthusiasm. The team has been training twice a week in Archbishops Park, and now that the team has been together for a little while, we should be able to go from strength to strength.

At this point a word from our sponsors...well we would have had a few words here, but at the moment we are looking for some sponsors to help with the purchase of some much needed kit.

Sarah Brooks and Claire Daniel

Marriage

Eric Tweddle LDS, RCS (1951), to Valerie Rhoda Lancaster on 16 November 1991.

Deaths

EDWARD, Pete Westbrook (qualified March 1942), on 19 November 1991.

BURFOOT, Harry, died the morning of 29 May 1992.

Situations vacant

Doctors/SRNs required to join volunteer medical team in southern Africa for 6-12 months. Accommodation, air tickets and modest local allowance provided. Would suit both the newly qualified and the more experienced. Please contact Jeremy McTeague on (071) 222 2933.

House for sale

Large 4 bedroom house in Blackheath for sale. Three reception rooms, 20'kitchen and adjoining breakfast area. In addition the house has a loft conversion and 120' rear garden. Recently double glazed with full insulation and gas central heating. Station 2 minutes walk. Price £199,000. Tel (081) 858 1856.

Computer for sale

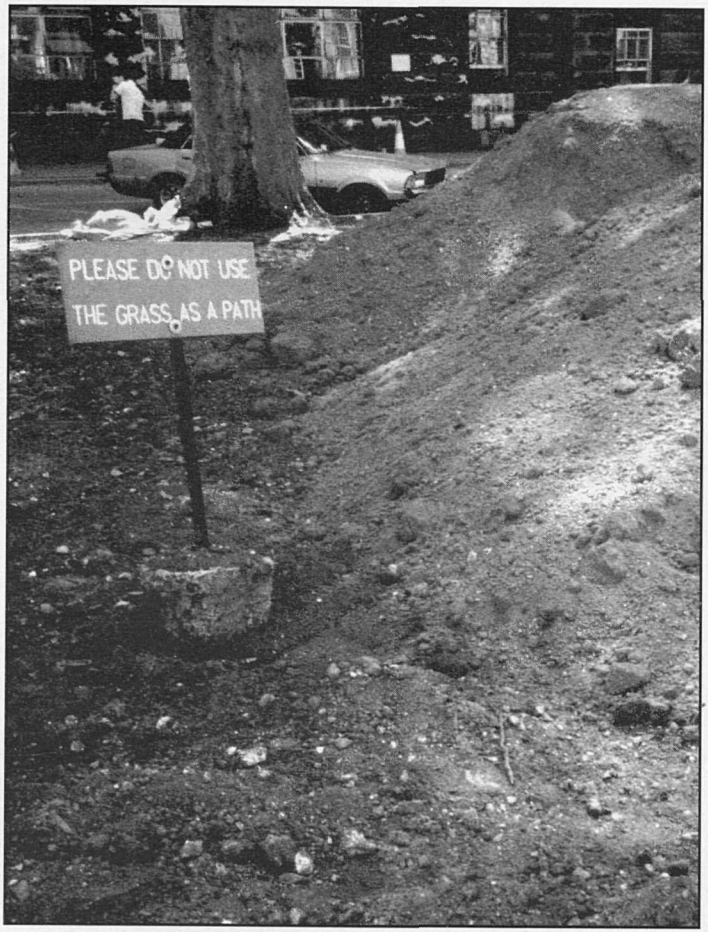
Amstrad PCW 8512—complete compact system with monitor, twin disk drives and printer. Programs for wordprocessing, graphs and others included. Inexpensive at only £200 ono. For further details, Tel (071) 733 9586 evenings.

Guy's Hospital — 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number is available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital — 250 Years, Guy's Gazette, Boland House, London SE1 9RT.



I always thought grass was the green stuff you found in the country

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GUY'S HOSPITAL GAZETTE

July 1992

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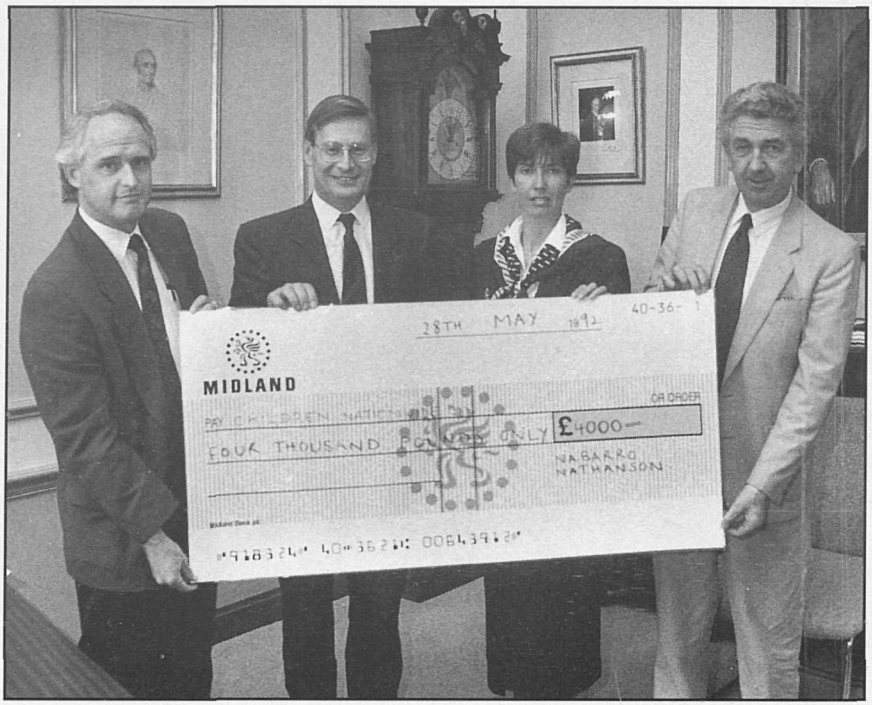
MEDICAL SCHOOL

- Patient Centred Care—a new approach to hospital design
- Rag Week 1992—who did what
- Spectrum UMDS—the first year



A cheque for £4,000 being presented to Dr Neil Dalton, Professor Chantler and Professor Haycock of the Paediatrics Department by a representative of Nabarro Nthanson. They collected the money for the Children Nationwide Medical Research Fund who support paediatric research at Guy's.

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Guy's Gazette

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The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

Just when you thought it was safe to get used to the idea of split-site teaching and UMDS as an institution, the 'powers that be' have signed a memorandum of understanding with King's College London. Coming at the end of the first decade of UMDS, and while there are still students entering their final years who were admitted to one or other campus, it is likely to lead many to wonder whether all the time, money and effort was worthwhile.

It is of course true that changes of this magnitude take time to implement. Indeed, less than half the history of UMDS has involved unified student entry. Similarly, even though an agreement for union with King's has been signed, it seems unlikely to me that any changes will be implemented in time to have a significant impact on the present student population. Let me stress however that officially, at least, no time-scale has been decided upon.

As with everything in life, advantages and disadvantages exist for most alternatives. No-one will argue that split-campus teaching is less than ideal for preclinical, or that the interest that many of our clinical teachers seem to have concerning which hospital we owe most allegiance to is a counterproductive one. I do however remember writing in the *Gazette* of December 1989 that with the consummation of the merger we should make the most of the two institutions and call ourselves Guy's and St Thomas's students—it was pleasing to see that when the new letterheaded paaper appeared someone (or some committee) had decided that calling ourselves Guy's and St Thomas's Medical and Dental School would be a good idea. Extending this principle to include King's would clearly enter the realms of the ridiculous. Much has been made of the benefits that might ensue from a multi-faculty education, and a broadening of horizons that would result by mixing with students of different disciplines. As far as I am aware, the proposals seem to suggest a life sciences faculty, rather than a complete spectrum of subjects. How about the loss of the facility for mixing with radiography, physiotherapy and nursing students? Also, what of the major changes to the curriculum that are currently being introduced. Teaching by systems is all very well, but it makes it more difficult to have common lectures with, say biochemists or physiologists. In addition, what of the exposure to clinical examples? In the new brochure *the first ten years* published by UMDS, it states that: 'On the first day . . . student dentists at UMDS meet each other . . . On the second day they meet patients'. Is this really going to be possible if the first years are spent based on a campus equidistant from Guy's, St Thomas's and King's?

One thing is undoubtedly true—the medical school and Memorial Park at Guy's provide a far nicer environment that either King's or St Thomas's. Admittedly St Thomas's is on a beautiful site, but King's can't even offer that.

Tribute to Red O'Flynn

Dear Sir,
It was with great sadness that I learned of the sudden death of Red O'Flynn. As one of his many house surgeons and former students, I recall his particular brand of humanity, humility and hilarity with which he treated not only his patients but all those who came into contact with him.

However poor the prognosis, of patients and personnel alike, his dry wit often saved the day. He routinely energised his surgical staff with regular supplies from the 'sweetie shop' which did little for the dentition but much for the demeanour.

I am not one to cling to the past, but with his passing another light has gone out on the old order, the likes of which we are unlikely to see again in our lifetime.

Yours faithfully,

PATRICIA A REYNOLDS
Department of Oral and
Maxillo-facial Surgery
UMDS

In appreciation

Dear Sir,
It is with great sadness that my daughter and family have learnt of the sudden death of Mr O'Flynn, so soon after his retirement. My daughter was on Martha ward for nine weeks from February 10 to April 10 1992. Her first operation was performed by Mr O'Flynn, and also two years previously it was he who operated on her. During her stay she had three operations in eight weeks and he visited her often. I stayed at the Nurses Home during that time, and whilst there I came across your beautifully produced magazine with a tribute to Mr O'Flynn's retirement.

We have been so pleased with all that the staff of Guy's Hospital have done for our daughter and had it not been for such dedicated people we feel certain we would not be enjoying her company today. I must just let you know that although she was on a life support machine and had two major operations in eight weeks we had the joy of seeing her get married on Saturday 9 May. So a great big thanks to Mr O'Flynn and the staff at Guy's.

Yours faithfully,

MRS M ELLIOT
451 Margate Road
Ramsgate
CT12 6SN

Championing choice

Dear Sir,
Whilst recognising the risk of being dismissed as humourless, we felt it necessary to register our concern at the tone of the letter from WTM Hale (*Gazette*, April 1992) on the establishment of Galaxy, a new club for lesbians and gay men.

He feels 'saddened' by the fact that lesbians and gay men should want to meet in the same way as those united by a common sport or other interest. His admitted ignorance and consequent sneering is surely demonstration enough

of the need for such a club as Galaxy at Guy's and St Thomas's. If gay and lesbian students and health workers are to meet this kind of prejudice for merely advertising their collective existence, it does not bode well for individuals at the two hospitals who wish to be open about their sexuality.

We urge WTM Hale not to revel in his ignorance, and not to dismiss what he clearly does not understand. Homosexuality is neither the 'organised cult' nor the 'dangerous contact sport' he describes. Trivialising the experiences of others is not the attitude we should expect from health care professionals. We would not tolerate the attitudes expressed with regard to other minority groups, and it is time such thinly disguised bigotry, even masquerading as humour, was challenged.

We offer Galaxy our support and wish it every success.

Yours faithfully,

JUDY GREEN
NICKY BRITTEN
NICK THOROGOOD
TIM NEWTON
C D ALLEN
DAVID GIBBON
CATHY POPE
LESLEY MILLARD
JOHN WEINMAN
PETER ROBINSON
UMDS

Playing dirty

Dear Sir,

I am disgusted by the lack of soap in the gentlemen's toilets on the first floor of Boland House. I find this situation unhygienic and totally unsuitable.

On posing the above point of view to the cleaners, the anti-social behaviour of a minority of students was used as an excuse for neglecting the toilet's upkeep. To answer this, I suggest that the punishment of a few unsavoury characters should not take precedence over the hygiene of the majority of the users.

I have resorted to carrying my own bar of soap! I can only imagine that the rest of my fellow toilet users are walking around 'unclean'—maybe the cleaners should keep this in mind when they next shake hands.

Yours faithfully,

J KABIR
Boland House

Bar invitation

Dear Sir,

The campus committee would like to take this opportunity to inform the doctors working in the hospital that they may make every use of the student bar. This invitation is open to all levels of the hierarchy here at Guy's, and I am sure that many past students would have no problems in finding this fine establishment, indeed some of them can still be found there reliving their youthful exploits.

Yours faithfully,

EDWARD SHARPLES
Vice President
Student's Union
Boland House

Memorial service for Harry Burfoot

The service of thanksgiving for the life and work of Mr Harry Burfoot, late Chairman to the Friends of Guy's Hospital will be held in the Guy's Hospital Chapel, St Thomas' Street, at 12 noon on Wednesday 9 September. All are invited to attend.

Funding stopped for Bloomfield Learning Centre

The Bloomfield Learning Centre, Guy's Hospital, is a teaching unit for children aged 7-16 years old with specific learning difficulties such as dyslexia. Originally founded in 1973 it has served hundreds of children from in and around Southwark. Without the intervention of the centre most of these children would never have achieved their full academic potential.

Children are referred to the centre by teachers, GPs, psychologists and parents. Each child is individually assessed and the appropriate help recommended. The Bloomfield Learning Centre is unique in that it has the support of a multi-disciplinary team within the Department of Child Psychiatry. Teaching sessions take the whole child into account not just reading and writing. On first attending the centre pupils often lack confidence and self-esteem. They have been failing at school and this is reflected in a poor self-image. Work programmes are devised to cater for the specific needs of each of these individuals.

Since the demise of the Inner London Education Authority, management of the unit was transferred to Southwark Education Authority. In August 1991, due to financial difficulties, Southwark withdrew funding. Despite the desperate need of many children within the borough, Southwark lack the means to support the service.

The two remaining teachers are determined to keep the Bloomfield Learning Centre open to as many children as possible for as long as possible. Charitable company status has been applied for and numerous organizations have been approached for funding. It is hoped that schools and local authorities will pay for their children to attend. If this is not possible some support may be available from educational trusts.

Any help or advice would be much appreciated. Please contact Jane Lloyd-Sherlock or Thomas Formikell on ext 4948/3904.

10th Anniversary research day

This will be held on 23 September 1992. The day is split into two parts. The first is in the morning at the Queen Elizabeth Hall in the South Bank Centre and admission is by invitation only. Several talks and posters will be presented. In the afternoon and evening, a poster display involving 200 posters will be held in the General Classroom at Guy's to which all members of staff are welcome. Refreshments will be served.

Quizzical cots

The Evelina Children's Hospital Intensive Care Cot Appeal is some £1,600 better off following a fund raising quiz night organised by the Southwark Heritage Association.

Teams from local companies assembled at Balls Brothers Hop Cellars function rooms, donated for the occasion. Participating teams included Barclays, Midland, Lloyds, Southwark Police and Sea Containers, who eventually won.

A giant cheque for £1,600 was presented on the night to Sylvia Sutton, the Appeal's coordinator.

Patients as teachers

Research initiatives launched recently by the King's Fund have suggested moving clinical teaching away from the hospital bedside and into primary care. Patients would act as assessors of medical students' bedside manners. Such teaching would particularly be relevant to understanding chronic diseases such as stroke.

Diabetes award for Harry Keen

The American Diabetes Association presented Professor Harry Keen, with the Harold Rifkin Award for Distinguished International Service in the Cause of Diabetes at their annual meeting at the end of June. The award recognises individual outstanding service for the furtherment of diabetes research and treatment in an international setting.

Professor Keen is Professor Emeritus of human metabolism and an honorary consultant at UMDS, and currently chairs the British Diabetic Association. Since 1962, Professor Keen has been involved with many international diabetes-related organizations including the European Association for Study of Diabetes and the International Diabetes Federation where he was named as Honourary President in 1991. The American Diabetes Association has previously presented Professor Keen with the Kelly M West award in 1989.

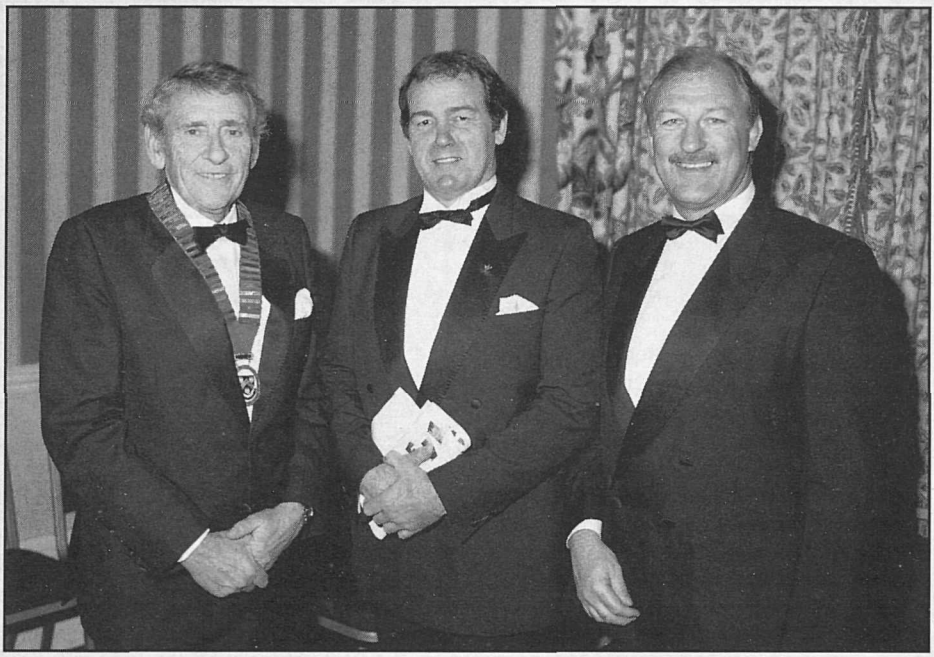
Lunchtime lectures

A series of lectures are taking place on Friday lunchtimes at the Old Operating Theatre Museum in St Thomas' Street at 1 pm each week. The lecture series includes such titles as *Plague, Pestilence and the Medieval Hospitals of London* on 7 August, *Dickens in Southwark* on 14 August and a play entitled the *Life and Times of Samuel Pepys* on the 21 August. The play lasts for 90 minutes while the lectures are only 35 minutes long.

Lunchtime lectures are also being held at the Florence Nightingale Museum, 2 Lambeth Palace Road on Wednesday lunchtimes at 1 pm. Entrance for adults is £1.50 at the Old Operating Theatre Museum and £2.50 at the Florence Nightingale Museum. Concessionary rates are also available for children, students and senior citizens. A season ticket allowing admission to both venues is available priced £20 (£10 concessions). For further details please contact Ginette Goulston-Lincoln on (071) 379 1561 ext 228/229.

Congratulations

Dr Richard Penny, who practices in Dulwich, has recently become one of the few general practitioners to be elected Fellow of the Royal College of Physicians.



South Wales Guy's Hospital Society Dinner—from left to right, retiring President, Mr Nat Howells, guest of honour, Dr John Davies and President, Mr Christopher Lewis. (**Photo:** STP Photography, Cardiff)

South Wales Guy's Hospital Society Annual Dinner

The 41st Dinner of the Society was held at the Park Hotel, Cardiff on Saturday 21 March 1992.

For the first time the Dinner was thrown open to guests including ladies. It was a major success with 86 persons present, plenty of good spirit and a fine meal. Speeches by Dr John Davies, Guest of Honour and by our President Mr Christopher Lewis were well received.

A few songs by a group of young ladies added to the evening and was a prelude to some less noteworthy singing later at the bar where the meeting ended.

Please note that the dinner next year will be held on 6 February (Wales v England at Cardiff Arms Park) and *not* March 7 1993 as previously announced. All enquiries to Graham Davies, Honorary Secretary, on (0222) 842479.

United Medical and Dental Schools of King's College?

The decision to unite UMDS with King's College London was finally confirmed on 3 July. This follows a two year period of discussions between the two institutions, and coincides with the end of the first decade of UMDS.

A joint policy committee, comprising the chairmen of the governing bodies, principals and senior staff, will examine the various issues surrounding the union. Details are not yet available regarding matters such as the site, timetables, how soon the changes will take effect, and of course the new name. Simon Argles, the School Secretary has volunteered a suggestion: 'United Medical and Dental Schools of King's College'!

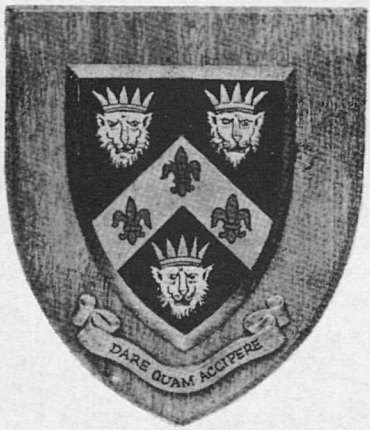
"Quote-Unquote"

'...if you look closely at the photograph [below], whilst Sir James Spooner [Kings] can be seen to be drinking water, Lord Butterfield [UMDS] is not only drinking champagne, but is also holding the bottle. Hopefully funds will be distributed similarly.'

Professor Ian Cameron
Principal, UMDS

Lord Butterfield (left), Chairman of the Council of Governors of UMDS and Sir James Spooner, Chairman of the Council of King's College London, drink a toast on the Terrace of the House of Lords to plans to unite their two institutions.

Guy's Hospital Gazette



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Rag Week 1992

A set of perspectives

It's a week before 'kick-off' and the T-shirts haven't been bought! Oh well, where's the fun in being perfectly prepared? That weekend before the start of the summer term saw an excellent range of frantic activity directed towards having Rag Week '92 start on time and run smoothly.

Daily trips to Harrow School, for Farida, Neil, Jess and several other volunteers, were made in order to assemble and compile the Rag Mag. At the same time on the first floor of Boland House, a workshop was in progress at which many learned the art of screen-printing. It was coming together.

So what was the point in the first place. Why bother to go to all the trouble of organizing fund-raising activities?

One good reason is that most people have fun. It's a chance for students to channel their social energies in an ostensibly constructive fashion. The staggering feature is how powerful mass-action can be if everyone puts their heart into it. No question about it, the commuting public at Waterloo, Westminster and London Bridge felt the force of our collective attentions. Occasionally one got the feeling it would be easier to get water from a stone. Sometimes it was quite depressing to see how pitifully unhappy people are on their way to and from work in the City. One couldn't help letting out a faint chuckle (tinged with guilt) when successfully getting a tenner off the more generous punters!

A second reason is that 'selfless' activities like voluntary work and fund-raising are a very traditional facet of British middle-class behaviour. UMDS is a very middle-class establishment and so it is hardly surprising that it should be a seed-bed for such honourable efforts.

A third reason is that it's a good excuse to organize a succession of booze-ups! This is an unescapable truth and yet undoubtedly goes down well with the people who do most of the work, namely the pre-clinical students. The *work hard, play hard* ethic is a feature of life in the medical, dental and other paramedical vocations. Unfortunately this kind of 'reward' for good works doesn't appeal to everyone. In spite of this though, a broad cross-section participated and contributed hugely to the success and enjoyment.

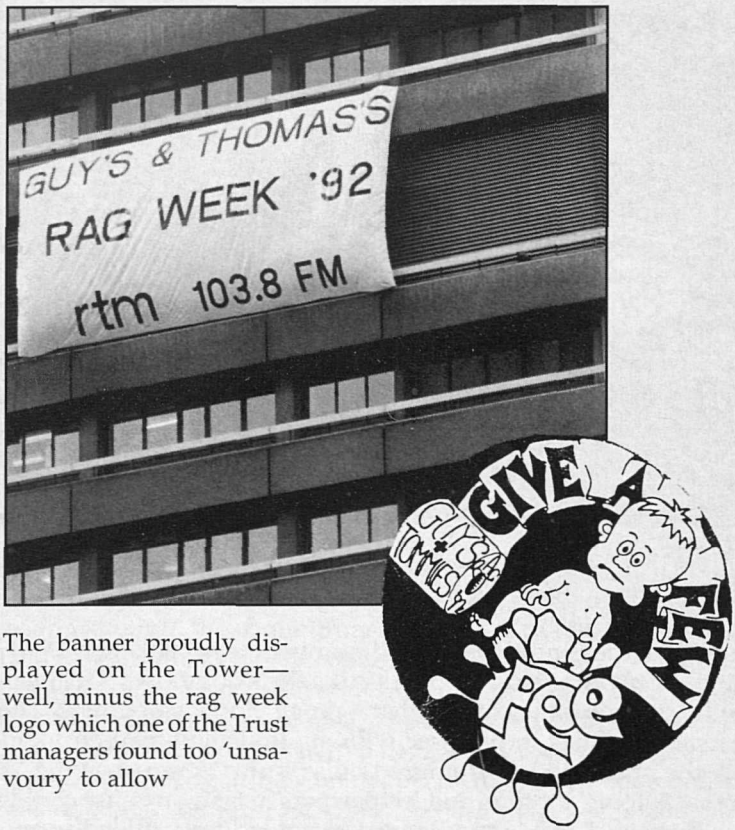
Bbzzzzt! I am a fly on the wall at the fashion show. Who are these shapely demi-goddesses sinuously gliding along the cat-walk? Too sexy for my car by far! Munita and Beccy must be related. I bet they shared their cot and playpen

Preparing the rag week banner

in similarly delightful chequered numbers way back then. And big sis' Katie putting them all to shame, looking like she's done all this many times before—absolutely gob-smackin' in that orange floral ball-gown. The compère, a barrister is a slick improviser with an amusingly barbed tongue and along with the other models, demure Louise, sultry, gum-chewing Yvonna and of course 'Adonis' Pittman and his partners in fashion-sense could have a future with Versace. Katie G and Beccy, I'm not kidding. A bloody good job!

The monopoly board treasure hunt was attended by a handful but still succeeded in raising about £900. Thanks Cecilia. On Sunday the venue was the Cutty Sark and a goodly gathering enjoyed the blissful weather subjecting the public to street entertainment of variable quality. Ian nearly managed to skewer a three year-old menace with the juggling knives. Shame that, give these toddlers too much rope... The collectors managed to raise a couple of grand.

Bank Holiday Monday saw a massive number of bounty hunters hit the streets wending their way to Covent Garden and raising some £4,000 in the process. That evening was the battle of the bands at St Thomas's. An excellent group from Charing Cross contested the adulation of the crowd with our very own Uzi Suicidal Penguins.



The banner proudly displayed on the Tower—well, minus the rag week logo which one of the Trust managers found too 'unsavoury' to allow

Tuesday saw Rag Week get under way in earnest. The scenes in Lusty's and the Spit when the Hit Squads rolled into action were hilarious. Crowds standing on tables revelling in the misfortune of the ones who got hit. It is a testimony to the goodwill and organization of all involved that all the mess was cleared up by those who had made it at the end of each lunchtime. The half-bearded first-years were also laudable in this respect after their shave-in. Even the biggest hits were not too vindictive. One poor chap, Julian if memory serves me, was 'caged'—for the readers who are unfamiliar with this curious ritual, the victim is locked into a laundry cart and has all the 'heinousness from hell' poured over him or her and is left to fester for a while—he was then taken

over to the Tower and put into a service lift, still in the cage and then his tormentors pressed all the buttons from Ground to 30 and left him to enjoy the ride. At St Thomas's one of the highlights was a trousers-down hit by the Girls' Hit Squad on Jimbo, who was then taken out into the street still naked and kicking and subjected to questioning about his indecent state by a pair of conveniently passing bobbies. (Who says the police are never there when you need them—Ed).

The other evening events included a real ale evening at Guy's with Jamie the pianist from The Goose, a karaoke at St Thomas's was another chance for the irrepressible extroverts to 'enjoy'. On Thursday Blockbusters took place, but unfortunately due to a technical hitch the eagerly awaited Blind Date had to be abandoned.

An account of Rag '92 is incomplete without reference to the final event, the Rag Masked Ball in Hay's Galleria. This was an unqualified success due entirely to the awesome feat of organization spearheaded by Helen, backed by Ellen and supported by a veritable army too numerous to mention. It was estimated that 1,100 paid to get in and that we were blessed with a handful (maybe 50) of non-paying guests—thanks for coming! There's no doubt it's an excellent venue and as well as entertaining most punters, it raised a huge £8,500.

It remains for me to thank Catherine, Neil, Beccy, Pete, Tim, Rob, Jo, Ben, Farida, Afrina, John-Paul, Charlotte, Judy and all the others without whose marvellous efforts nothing would have happened.

Notably excellent contributions from the freshers included those by: Will, Horace, Riki, Sam, Sonia Rai, Declam, Ashok Subramanian, Farah, Vanessa P, Sunil Nair, Ruth Selwood, Stuart (for getting to the top of the Navigator at the Ball), Tony Kochnar, Simon Hughes, Natasha Kaul, Chris Davies, Richard Crowson, Amanda Bond, Hugo Wilson, Arucha Anderson, Steve Arnold, Sammy Darwish, Valerie Haywood, Alexander Boulger, Ed Lawson, Sarah-Jane, Kieron, Harvey, Suzanne Moore, and last but not least John Swift. There were I'm sure many others who also contributed handsomely, thanks to all.

You were great!

Tom Brink

Reinventing the Hospital

Patient Centred Care—healthcare for the 21st century

Andersen Consulting, the consulting arm of Arthur Andersen Worldwide Organization, has carried out a survey of NHS hospital organization, processes and staffing. The survey includes 10 NHS hospitals within the UK and was supervised by Andersen Consulting's Dr Nicholas Edwards.

The starting point for Dr Edwards is that with the advent of the patient's charter, purchasers, competing hospitals and current demographics hospitals face major external challenges and the time has come for a fundamental rethink of how care is delivered. He criticises the current hospital organization of *departments* and argues that this causes excess movement of staff and patients. In addition he argues that departments have excessive job classifications—he quotes the average hospital as having 221 job classes. This leads to *demarcation*—where individual members might argue about tasks, for example, does the doctor or the nurse give intravenous drugs, and *alienation*—where individual members due to their specialization lose the overall concept of ill patients coming into hospital, being treated and going home well.

The results of the survey show that the average junior doctor walks seven miles (three hours) during a normal working day. When on-call this distance rises to a staggering 16 miles per day. It is the sort of journey most people would take exception to in getting to work. Auxiliary nurses and other staff also travel substantial distances in the course of a working day. Nurses, the survey claims, only spend 40% of their time in direct care of patients, 20% in indirect care and another 40% associated with non-productive work. From the patients' point of view the survey concludes that in a typical hospital an average patient meets no less than 47 different care-providers during a five day stay.

The survey also studied the function of the laboratory processes which it found to be complex and involving numerous people. Three variables were studied in the request for a urea and electrolyte investigation from the biochemistry laboratory. The survey found that on average this simple test involved 60 steps, 11 people along the chain and took 18 hours to complete. Maximum times were much higher. Junior doctors are spending a significant amount of time on administrative, clerical and other distractions from patient

care (when they are not walking around between the various departments). Dr Edwards gave an example of an interventionist study in the USA where the laboratory test process was reduced from 18 to eight steps—a 56% decrease. The comparable turnaround time for the test was reduced from 466 minutes to 23 minutes. This reflected a 95% saving on process time.

Andersen Consulting highlight the following problems in the NHS hospitals of today:

1. Hospital organization is based around departments and not patients. This leads to communication difficulties and increased travel.
2. Hospital processes have evolved—not been designed. There are too many steps involving too many people.

In studying hospital organization and logistics Dr Edwards said Andersen Consulting has developed a new approach to running hospitals which will improve the quality of patient care and increase staff morale and job satisfaction. This he calls *Patient Centred Care.*

The objectives of Patient Centred Care are to *rationalize, simplify and refocus.*

Rationalize

This involves a complete rethink of hospital organization. The traditional wards and departments are to go. In their place Care Centres are to be introduced. Patients are to be grouped sharing similar characteristics and resource usage. The care centres will include a mixture of inpatient and outpatient (traditionally separate entities). With the advent of smaller, cheaper and more automated equipment the care centres are to include high volume diagnostic equipment such as equipment for plain radiographs, full blood count test and urea and electrolyte test. Although the theme of rationalization involves decentralization of processes and equipment, the cost of some equipment eg MRI scanners, requires that it be operated centrally. It is suggested that these machines can be situated on care centres where their use is maximal and that way the minimum patient travel to equipment is needed. Decentralization of equipment means that staff are required to be multi-skilled so they can operate the equipment. Nursing on the care centres is to be a modification of the concept of Primary Nursing. Each patient is to have a care assistant who will liaise with the medical staff. This way a more personalised level of care can be delivered.

Simplify

There is lots of scope to simplify tasks in the newly organized health service. Arthur Andersen argue that since the current organization has evolved rather than been devised, it is complex and inefficient. Tasks can be broken down

into fewer steps and with multi-skilled staff fewer individuals will be required to carry out the processes. Turnaround time can be considerably reduced this way.

Refocus

The new organization of the health service is to be focused around the patient. This fundamental assumption is to include the physical layout of the hospital, how jobs are performed and responsibilities for individual tasks. Rather than the patient travelling to different departments around the hospital for routine tests these can be brought to the patients on the care centres by multi-skilled staff. Phlebotomists and intravenous teams can visit the patients as required.

Almost nothing that has been suggested by the Arthur Andersen survey above is new. Individually they are being performed at various hospitals around the world. There are hospitals operating phlebotomy and intravenous teams, others are engaged in primary nursing. Some of the newer hospitals in the USA and the Far East have a decentralized physical organisation.

These processes have their inherent problems which the Arthur Andersen team failed to mention. The cost of implementing these changes are phenomenal in many cases. For some of the present hospital sites the decentralization process may be impracticable due to the structure of the old layout. The staff for whom it is claimed the benefits of the new organization is for may not be too pleased at having to do extra duties. Multi-skilled nurses who are expected to operate the new ward based analyzers in place of 'non-productive work' may not be happy if their renumerations are not increased. Doctors who might save three hours a day (and seven miles of walking) will not be pleased if that time is scheduled for more intensive work, operating more and increasingly complex machines.

There are very many encouraging suggestions from the outcome of this survey. Indeed to take the patient as the all important factor in the healthcare organization can only lead to improvements in quality and service. It is an adaptation of the 'consumer is king' philosophy in retailing. The limitations of these ideas are also significant. In a world of increasing complexity and expectations where the life and burden of work for health care providers is already difficult it would be unforgivable for non-medical professionals to suggest that we are being inefficient and must work harder for the same renumerations.

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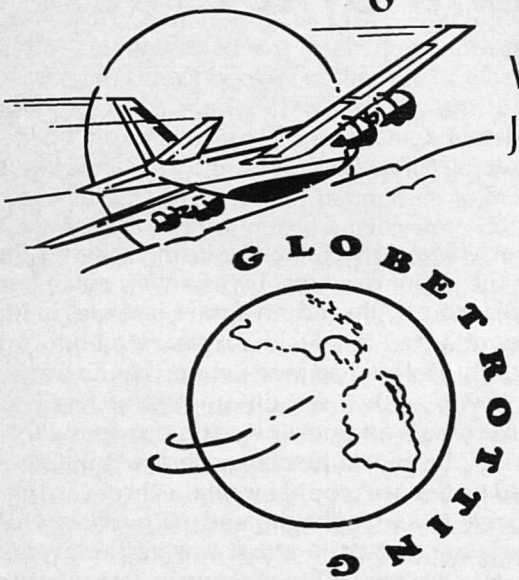

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Life on the End of a Liver Retractor

Dr Pitt-Payne—senior surgical dresser

I found myself on the Blackburn/Maynard Firm; the former having the senior dressers and the latter the junior dressers. I was a very small boy indeed when I first met Guy Blackburn. He and my father had met in the theatre of the war where Guy was attached to a Field Surgical Unit and my father to a Field Transfusion Unit. My mother had warned me that he wasn't a man to suffer fools gladly so it was with a certain amount of fear and trepidation that I awaited his ward rounds and never was I more on my toes than on these occasions. Back in 1967 he gave a lunchtime lecture on 'Carcinoma of the Thyroid' where he told us that we would forget the three cardinal symptoms of the disease, viz hoarseness, dysphagia, and pain. Somewhat obstinately, I will remember him saying that as though it was yesterday, but when it came to a case of Ca Thyroid in my own office recently in a young man of 30, I duly forgot as he had said we would and only knew what the matter was in retrospect. I did refer him on but for reasons which must have presented at a subliminal level—on the grounds that the poor chap didn't seem too well and had a husky voice.

It must be a while since an old lady came to see me: 'I was knocked down by a bus yesterday, doctor.' she said.

'Oh,' I replied, 'was it a 126 or a 138?'.

'Does it make any difference?', was her reply.

Similarly, there was another senior citizen who was lying in bed when I got to her:

'I spilt a cup of tea all over myself this morning, doctor.'

'Was it Chinese or Indian?' I countered.

'Oh,' she paused, '...is there a difference?'

It must have been on the Senior Surgical Firm that everything began to fall into some kind of shape. We were blessed with a very brilliant young fellow as senior registrar, one Bill Heald (now consultant surgeon at Basingstoke District Hospital). He it was, who had got his Fellowship and M Chir at the fantastically early age of 27. Never did I see a man who more enjoyed himself

at every level of his job. On take-in, his enthusiasm was infectious and he taught us every step of the way. Early one morning, and towards the end of a particularly stiff test of his skill—which had involved a bleeding duodenal ulcer—he suggested we might have an omelette. I and another were despatched to collect eggs from the wards; a hazardous business when Sister Rix was cruising around the building. I was in the kitchens on Astley Cooper Ward when I became aware of approaching footsteps. Having no wish to be caught in the act, I shot out of the kitchen and down the ward to the left where there was a patient we had admitted earlier in the evening on the previous day for a suspected leaking aortic aneurysm. Although it was pitch dark, I knew where his bed was and as I tried to find his pulse it occurred to me that he had passed on. I froze. It's not a nice thing to find a deceased person in the dark and I could see there was a night sister at the Nurses' Station but it wasn't Sister Rix. I approached with caution and said quietly that one of their charges had joined the choir invisible. I don't think they believed me for a moment but they had to agree that our patient was dead.

'Anyway, what were you doing up here?' I was asked eventually.

'I had a premonition.' I answered.

'Humph!' was their response. I don't think they were too pleased that one of their charges had made good his escape, and so I made good mine, and when we came to it, it was as fine an omelette as I ever tasted.

We were seconded down to Lewisham Hospital for two weeks at a time and here we saw a wide range of surgery in the raw, as it were. We were taught by a brace of surgeons, Mr Le Brun and Mr Lynn Evans. Mr Lynn Evans was a tireless worker who tended to swear in Welsh. I know this because his houseman, Bill Owen, told me. I remember an operating list starting at two in the afternoon and ending at 1am the following day. There was an aortic trouser graft in there somewhere. I looked at my watch. It started at 8pm and ended three and a half hours later. We were sustained with coffee and sandwiches. His registrar, Mrs Osmani FRCS, was pregnant and tended to morning sickness and when she suffered and retired for a break, I got to swing on the end of the liver retractor instead of Bill Owen.

Mr Le Brun operated on Wednesday afternoons. He had a penchant for the total gastrectomy entering the field of operations via the trans-thoracic route and swinging up a bit of large bowel on the pedicle of the middle colic artery which then filled in the gap between the oesophagus and duodenum. It took time and one occasion I was scrubbed up and assisting for seven and a half hours. Though the scene resembled nothing short of carnage it was—surgically speaking—a *'tour de force'* and all the cases he undertook whilst I was there survived.

The Lewisham accident and emergency department kept us busy stitching and sewing. One night there was a gruesome case. A teenage boy had been leaning out of a railway carriage as it sped along and a signal gantry took off the top of his skull. He was brought in and I was first on the scene. His teeth were tightly clamped shut and his airway was beginning to obstruct. Never did I feel as helpless as I did then but the anaesthetists arrived very quickly and intubated him. I watched the full horror of the injury reveal itself and over the next few hours followed the case through theatres until he died on the table. A fascia lata graft was attempted to cover the skull defect and my job was to get blood into him with one of those gadgets called a Martin's Pump where I turned a handle endlessly with seemingly little effect to get blood into him as quickly as it was coming from the exposed surfaces of his brain. It cured me of hanging out of railway carriage windows, and the images of that night are still with me.

Back at Guy's, Guy Blackburn was operating upon the thyroid gland. In his hands the thyroidectomy and it's post-operative care had become something of an art form. The atmospherics in theatres when Guy was operating made me feel I'd entered the cathedral-like environ of a gentleman's club. He was very much the 'big white chief' of his subject and at the bedside or in outpatients he was a charismatic figure with his repeated allegorical warnings and his wagging finger. As an examiner in surgery finals, he had a reputation for touchiness and when a student had been very mindless, Guy—it was said—would take him to the window and ask him the colour of the leaves on the trees. If they were green, the student was invited to return when they were brown, and vice-versa. The nurses were in awe of him and he could be somewhat frightening when he was wiping the floor with someone, but if any nurse or medical student needed emergency surgery during his week on take-in, Guy Blackburn would be there for them, and then take great care of them; something they never forgot, I'm sure, and forever after they were devoted fans, as I was.

One or two images remain. There was a retired priest who was allocated to me and he had had a partial gastrectomy. With the tube up his nose, and little prospect of it being removed due to an abiding ileus that seemed to be going on longer than was decent, he had taken to reading. One day, I peered over his shoulder to see how he was passing the time and saw he was reading a book by Soren Kirkegaard. As I had no idea who this geezer was, I made a few tentative enquiries, and remained none the wiser. Then came Guy Blackburn's round and he made a policy decision : 'We'll put up a rectal drip, Sister.' After this, there was no more Kirkegaard and the poor fellow only got his smile back when the drip came down; or in his case; out. My associations with Kirkegaard

are still negligible and whenever his name is mentioned, I think of this clergyman, the rectal drip and paralytic ileus.

In those days the treatment of diverticular disease was very much the low residue diet and over the next 15 years or so (thanks to the work of surgeon Captain Cleave RN who had treated constipation afloat, as it were, for 30 years) the management of the bowels went through a 180 degree turn. Such were things that some wag was moved to write upon a wall:

'Eat bran and watch the world drop out of your bottom'.

Burkitt told us that the perfect stool was two and a half turns and pointed at both ends, and the nation—as a whole—were either 'sinkers' or 'floaters'. We all looked forward to happier times in the toilet but the gastroenterologists were not finished with us yet and the colonoscope hoved into view giving a whole new meaning to the term 'looking up old friends'.

In every practice there are patients who carry things a bit far and one such individual had taken to assessing the weight of his stools. I was slightly startled one day when he engaged me on the doorstep after a somewhat protracted visit to his wife. At times like this he would lower his voice to a confidential murmur much as my barber used to when going up the back of my head with his electric shears. If you'll pardon the expression, I had to strain to hear every word and at times I don't think I could believe what I was hearing. This fellow had taken to playing a form of 'Pooh-sticks', but instead of standing on a bridge and throwing twigs in the water and rushing to the other side of the bridge to see them flow past, he used to chuck things into his alimentary canal and see how long they took to go through and emerge at the other end.

Only the other week, there was a chap who swallowed a 10p piece and attended soon after his wedding in some discomfort. The coin had decided to stay in his stomach. Somehow he had managed to swallow it on his stag-night. I duly went through the motions (sorry about that) and announced in my most serious voice that if there was no change by Monday he'd better let me know. At time of writing, I am pleased to say that he got his money back. The coin in question has now been inserted into a champagne cork saved from his wedding breakfast.

The take-in dinner on Saturday nights was still very much an institution and the 1st XV still arrived late in the proceedings and enlivened things considerably. There were times when we would be called to casualty and some of them would come with us and lean all over the stretcher rails and interject with questions of varying density according to their refreshments taken so far. To say that they emitted fumes would be putting it mildly. As often as not they would adjourn to a nearby curry house and eat unspeakable things that made

them very unpleasant to stand next to the following day on a ward round.

At about this time we were in the throes of taking midwifery and pathology conjoint finals. These examinations are a bit of a blur now, but they did occur during June/July 1969 for our year which had arrived at Guy's in October 1965. Medicine and surgery had to be taken separately in October 1969 and January 1970. The Final MB BS would be in April 1970. There were frequent protracted rides on the Northern Line towards Queen's Square to those examination halls where we would spend an inordinate amount of time.

I think there are many of us who have cause to be grateful to Dr Brown at Hither Green Hospital, who took us for courses in Pathology and it was he who got many of us through what amounted to rather a tricky little exam. The vivas were terrifying to begin with and it took a while to get the hang of things. I got Miss Anderson from Lewisham Hospital for the gynae and obstetrics viva and it was rumoured that she was asking questions about iron deficiency anaemia in pregnancy. Luckily for me, this was indeed so and I got off lightly. There was a tricky moment int he medicine viva and I could have sworn I got a consultant psychiatrist asking me the questions and he gave me a sticky time of it. When I heard the bell go, I breathed a sigh of relief—and he must have seen this—and said: 'Alright-the bell's gone; now give me six common causes of haematemesis.' I glared at him; making a mental note as I did so to cross him off my Christmas card list, and spat out the information required. I was lucky again. Another student wasn't quite so lucky in that he cited the Mallory-Weiss Syndrome as a common cause. The reply went something like this: 'Yes-I'd put that 15th on the list and sword-swallowers struck by lightening 14th!'

I got Professor Spector for pharmacology and therapeutics and breathed a sight of relief. He was as benign and as friendly an examiner as one could have wished for, and asked me all about purine metabolism, Dalmatian Coach Hounds—and the like—all of which I got along with quite well. His companion on the other side of the green baize, sensing that things were going a little too well, then sent down an absolute yorker of a question which very nearly caught me off my guard and I felt the proverbial bails trembling on their metaphorical stumps. Whatever may be said about the conjoint diploma today, it was certainly no sinecure then and many of us gave more than a passing thought to getting a ticket for the apothecaries final examinations. By October 1969 well over 90% of us were three-quarters qualified and most of us had sat the MB BS pathology finals with varying degrees of success.

J H Pitt-Payne

Which Pond to Swim In?

Considerations for choosing a speciality

This month, we continue Sir Alfred Fripp's lecture to medical students. He advises on how to select a speciality to suit the individual, the importance of making the right decision for happiness in one's career, and above all, how to strike a balance.

'The Art of Living'—part II

Let us consider the prospects of each individual who comes into this profession at this interesting epoch in its history, and how he may improve those prospects. Incidentally it is obvious that he starts his battle of life with the whole world in a condition of unrest consequent upon the war. Apparently there are fresh values for everything, social, political, economic, artistic and even moral. One of the byproducts of this world condition seems to be a curious new relationship between the public and the doctors. Another is an extraordinary nonchalance with regard to operation risks.

Next let the aspirant to success ponder the fact that in any profession, just as in commerce, it is one thing to have goods to sell and quite another to persuade the public to come and trade with you. You will leave the hospital endowed with certain wares which you want to market, and since you have acquired these wares at Guy's you will find that the stock is better than that owned by most of your rivals. Their acquisition has cost you much time and energy and money and now you have got to persuade the public that you can supply their demands.

Manner as well as matter

To put the same thought in other words you have to remember that throughout life just as in examinations—and by-the-by the candidate often forgets this point in examinations—marks are allocated for *manner* as well as *matter*. All of us can recall instances of men getting spun when we, who had the best experience of their qualities, felt sure they knew enough to get through easily. The trouble often is, as Smee said of the crocodile, 'He knows, but he cannot say.' The same lack of ability to bring his goods to market probably explains the tragedy of J K Ss

'Grave grey lawyer in King's Bench Walk

Whose clients are passing few;
He seldom speaks; in these lonely weeks
What on earth does he find to do?
Well! he stroked the Eight! What a brilliant fate!
And the Newcastle barely missed.
A future Lord Chancellor—so we'd thought
In the days of the old school list!

Anybody who would win success and happiness in our profession must bear these words and other facts in mind and he will find that it is man's work, not boy's. For the Art of Living can only be studied after one has come to years of discretion.

The first question each qualified man has to determine for himself after recognizing the elementary facts already alluded to is, what pond does he elect to swim in? Is his desire to choose a pond in which he can become the biggest fish? Where does he choose to put up his plate? Or, in other words, what public does he choose to cater for? Does he elect to go into general practice, or some speciality? Does he wish to work in the town or country? In a large town or a small one? It is almost the last opportunity he will have of making a free choice about anything in life so let him ponder it well, let him begin to study it early—the answer is well nigh irrevocable, and upon it his happiness depends.

Take care *lest* you find what you seek

Some are fascinated by the laboratory life, but only if they are endowed with abundant private means can even these afford to ignore the opinion of their particular public. The only piece of advice I will venture as specially appropriate to this class—though useful to be remembered by us all—is what I was told one great scientist had the courage and forethought to have written up round his laboratory, 'Take care *lest* you find what you seek.' If this injunction had always been observed perhaps we should have seen fewer fads ridden to excess. Let us be warned by such happenings in the recent past, and by the sport which publicists like G B Shaw make of them, to the detriment of the standing and proper influence of the whole of our profession. It cannot much benefit the our reputation in the public estimation to hear a consultation nick-named 'a conspiracy.' Let us be careful that in future such mud-throwing is not justified, even when the thrower has taken out a license as a clown.

Similarly any premature publication would be shunned by all who claim to be true scientists. For science means knowledge, and not guessing, and when guessing and attractive jargon are used as a basis for money making there is

soon dirty work a-doing. People whose pseudo-scientific publications and whose conduct conduce to such practices are real danger spots in our profession, especially when they bear names which exercise prestige-suggestion over the unthinking herd.

The pose of the clever but unscrupulous finds great scope in our profession—for a time. It is absurd of course that men should be taken at their own valuation—even when based upon published statistics. But poetic justice is usually meted out in the end. Charlatans have risen to fame on many an unjustified claim—even on ability to attain sex-determination! Perhaps the abuse of psycho-analysis is as great a menace at the present moment as the 'opsonic index' and the 'nuciform sac' proved in the recent past.

You see there is always a section of the public on the look-out for new fads, just as there are plenty of people foolish enough to believe anything said by a prominent individual. They are the ready prey of any poseur so long as they can think his stunt is new. They resemble the class that is always on the look-out for a new sensation-or a new dish—it has been said that the restaurant cook who could invent a new dish would be a millionaire tomorrow! They worship the *dernier cri*, and they are the makers, and very soon the breakers of the latest wonder-doctor of society, 'poor spoiled darling of the hour.'

Enough said—I will not risk libel; but think it out, and there will come in to your head as appropriate the old thought that our little systems have had their day and cease to be.

Others among you may feel drawn towards one of the Services, with its assured conditions, its fixed pay and pension; the majority will go into some form of private practice. Every one of you wherever your choice falls must remain a student all his life.

Every one of you must be a researcher, but remember there is something finer even than research and that is resolution. Resolution always gets results, research may. And everyone of you must cling to your health as long as you can. Every man to keep healthy needs—as Pinero said—a horse and a hobby horse. He needs exercise and he needs a hobby to take him out of his work. He should become a connoisseur in something—even if it is only in butterflies or beetles wings. But he must be healthy in body and spirit if he would best help those who seek health. So take up some healthy hobby early in life. It will help you to relax—to switch off—which is an accomplishment of incalculable value in any busy life.

Every artist recognizes the necessity of occasionally standing back from his easel. Our profession affords a wonderful training for watching and assessing the value of details. Many a successful doctor has won eminence in his hobby as well.

Next do not be afraid of making honest mistakes. It has been well said that the man who makes no mistakes makes nothing, but the man who succeeds is he who repeats the fewest mistakes.

'Every failure is a step advanced,
To him who will consider how it chanced.'

So let no experience be utterly forgotten, rather try to let yourself become part of all that you have met. I am a firm believer in the abiding value of storing in ones memory each good thing one comes across—wherever one comes across it. What a pity one cannot always remember the attribution of all the good sayings one has always come across. But you won't remember them unless you grow the habit of jotting them down—and of going through your jottings when next a wet day during you holiday affords the time. You will find it more pleasureable and more profitable than reading the latest 'shocker.'

Know what you know

Do not mind admitting that you 'do not know,' even at your examinations. It is striking how much you will be forgiven for not knowing, and how soon you will be pilled if you guess. For the guesser in our profession is a real danger to his patients, perhaps a greater danger than the symptoms which made them come to him; and the fool in our profession is the man who does not know what he does not know.

Do you remember that old Arabian jingle which runs:

'He who knows and knows he knows,
He is wise—follow him.
He who knows and knows not he knows,
He is asleep—wake him.
He who knows not and knows not he knows not,
He is a fool—shun him.
He who knows not and knows he knows not,
He is a child—teach him.'

Those who elect to work in the fields of private practice must recognize the difference between being educated and being clever. No degree will carry you to success unless you develop those personal qualities which are wanted by your public. Mere talents may suffice in government service or in any branch of research or of academic life, but you want something more to earn success as a practitioner—and only by studying the humanities can you gain that something.

In no walk of life is it more true that the proper study of mankind is man.

Cultivate the art of listening, learn to grasp the essentials of the situation, to be quick in the uptake—so you will learn to treat the individual as well as the disease, and to allow for his temperament and his tastes. You will realise the value of that kindly word which puts people at their best, the danger of first impressions and impulses, and the desirability of postponing judgement, where you can without detriment. You will learn to recognize and to appreciate solid ground affording sure footing; and standing on the definite and proved, you will find abundant opportunites for peering out into the indefinite, and watching developments and wondering how soon the pendulum will show the inevitable back swing from the extreme to which it is always pushed by the enthusiastic innovator. Faddists and fanatics and even rascals there always have been and there always will be, both within and without our profession. They flourish upon the rustic ignorance of the public in matters of health. Watch them, and more closely still if they come in attractive guise, and don't swallow assertions just because they are novel or bizarre. Buy truth but never sell it. Beware, once more of the medical or surgical stunt.

Practice organization from your earliest years. Plan your work, plan your hours, it will help you to economize time and effort.

Enlarge your experience by grasping every opportunity of travel either on a large or small scale, and by devoting such reading time as can be spared from your professional work to the great writers. By this means you will combat the tendency to narrowness of outlook, or grooviness, which too often stamps men who have to lead the strenuous and exacting life of the hospital. And each of us however busy can find time for general reading, especially if we avoid the waste of time which is entailed by poring over a multiplicity of newspapers and magazines, and by indulging inordinately in games, whether of cards or what not, to which no health or other profit attaches. To put it another way spend your time rather over such pursuits as will help you to create a demand for your personality. It is not enough only to supply a demand.

Practise speaking in public. You will be surprised how much it tends to clarify your views, and what a degree of confidence quickly comes as soon as you have got over the feeling of shyness and novelty which besets every man the first time he hears his own—apparently extraordinary—voice in public.

Avoid appearing to be in a hurry. Celerity as distinguished from haste, should be the accomplishment rather than the obvious aim of the surgeon. As a very worldly-wise lady once said to me, 'The greater his need for hurry, the more the necessity for the doctor to take a chair and sit down as if he had plenty of time to devote to this patient should the case demand it.'

Avoid pathological details in your report to the patient or to his relations. They will not be understood and very likely they will be misinterpreted.

Seldom tell a patient about 'a case in point'—it will profit neither him nor you.

Always remember *never* to use those two words.

Differentiate your Sundays. The noble art of rational enjoyment must be fostered. The regular holidays, even the regular sleep at nights, which can be relied upon by men of other professions, however busy they may be are denied to us, and no man can work all the days of the doctor's year without detriment. One day in seven should be spared all but absolutely essential work. Even a doctor requires to bow to the requirements of his own engine. It needs some recuperation, yet he is apt to illtreat it worse than his motor—forgetting that he cannot buy a new one.

In order that you may make as few professional side slips as possible, be ready with your next step—the doctor who shows obvious hesitation is lost. Just as you must protect yourself by X-ray examination before anybody else has time to suggest it, so always be the first to propose consultation, and, very important, give the family the chance of selecting the second opinion. Some men seem to consider such conduct a confession of weakness. It is nothing of the sort. It demonstrates your open-mindedness and your desire to help your patient, and I promise you it will do you no harm but only good in the eyes of your public; you will rise in their estimation of your reliablility. But, consultation or not, the moment comes when it is better to take any step however desperate than to leave the patient to die, if there is any chance of avoiding that certainty.

Surgery is not only a question—is not so much a question—of what can be done—given anaesthesia and a circular saw there are no limits; but rather a question of what should be done, of what not to attempt. 'Brilliant operation—patient dead,' is not a bulletin that is helpful to you or to your great profession. Beware of operations done for pain alone—unsupported, that is, by other indications. It is safer in surgery to begin with a little scepticism.

Don't operate without asking yourself the reason why. Only the acute abdomens and some obvious tumours and traumas should be operated upon without first calling a physician into consultation. To be an operator is one thing; to be a skillful operator is another; to be a great surgeon is far greater!

The operator whose statistics show 100% success is a danger-spot; he is not fit to be a surgeon at all for he is—well, an economizer of the truth—no operation has ever earned 100% success, or ever will. The man who talks as if his experience and his statistics were so much better than other peoples just 'makes me tired.' He will do less harm to the profession and to himself in the long run if he confines himself to fishing stories. You remember that classification of liars by some lawyer into Liars, Damned Liars and Skilled Witnesses?

Don't forget that there is a right and a wrong way of doing everything—however apparently trifling. It is not easy always to do anything—even the most trifling—properly. Concentration and painstaking practice are essential, and even when you have acquired an art don't let familiarity breed contempt. Take care of details—a burnt heel and musculo-spinal paralysis go far to mar the impressions of a successful operation. Indeed surgery is a *craft* as well as an art and a science, and there is room for gentleness, forethought and consideration as well as for dexterity and cleanliness.

The words of wisdom continue in the next *Gazette*.

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Recently cleaned Shepherd's House and the newly landscaped Park play host to the Summer Fête
(**Photo:** courtesy of the Photo Club)

Brisk business at the food stall
(**Photo:** courtesy of the Photo Club)

Community Respite Care Makes Better Doctors

Spectrum UMDS—one year on

Eight medical students in their second preclinical year are visiting families with special needs children as part of a pilot scheme set up at UMDS in the Summer of 1991.

The scheme, called Spectrum UMDS, is a student initiative in response to the perceived lack of education concerning the long term needs of such families in the community. It should help to broaden student awareness of disability and to foster a more sensitive and understanding approach towards such families and children in future doctors graduating from UMDS. Spectrum will also add to the struggling voluntary sectors of community care in south London boroughs, where provision of care falls far short of demand.

Spectrum UMDS is inspired by the original Spectrum scheme which has been running at Royal Free Hospital Medical School since 1982 and now includes medical students from University College as well. Quotes from students involved include:

'I am beginning to understand the mountains they [the families] have to climb';

'Great fun';

'The children involved in the scheme are absolutely wonderful'.

Parents also seem to appreciate the Spectrum scheme and have voiced some of its beneficial effects:

'Both my children look forward enormously to our link's visits each week';

'It has given him [my able-bodied son] a valuable insight into and an understanding of his brother's condition';

'Respite for me and great fun for the boys'.

Students, parents and staff of the original Spectrum have been extremely helpful in the setting up of the new Spectrum at UMDS. We hope to work together to encourage students at medical schools all over the country to set up new Spectrum schemes.

Students involved in Spectrum UMDS are linked on a one to one basis to families provided by a voluntary scheme in Lambeth called Family Link. We

aim to include families from Southwark, Lewisham and other boroughs in south London in the near future. Childrens' special needs range from learning difficulties to physical disability, including a range of different conditions; hence the name, 'Spectrum'. Students become a 'special friend' to the child. The family's needs and satisfaction with the scheme are monitored by Family Link, while the student's needs and problems are monitored by the student representative on the Spectrum steering group. There is also a regular support group for volunteers facilitated by the student counsellors, Diana Bass and Paul Pavli. Students visit the families regularly, as often as possible, and look after the child or take them out with all expenses paid by Spectrum. We hope to have parties for all involved and perhaps day-trips or holidays for students and children in the future.

In October 1992 we are having a Freshers Week recruitment drive for new volunteers as we move into the second phase of the pilot period and increase our membership from the original eight students, who have been the patient and helpful guinea-pigs of the scheme. But Spectrum is not just for preclinical students—the students visiting at the moment hope to continue their links as long as they can into the clinical course, until attachments and electives make it impracticable. At UMDS we are also looking at the possibility of including nursing students in the scheme.

We would like to thank all who have helped to make Spectrum work, including the medical school chaplains who kindly gave us some of their office space.

Anyone interested should contact Maya Albert at the Spectrum office, St Thomas's Hospital ext 2648, or on (071) 607 6546.

Maya Albert

The Thymus. M A Ritter and I-N Crispe. Published by IRL Press. Price £6.50

The thymus has a chequered history, during which many functions have been attributed to it, including that of secreting the elixir of eternal youth. Although it cannot provide immortality, the thymus does play a central role in staving off the Grim Reaper.

Jacques Miller, in 1961, showed that thymectomy of newborn mice resulted in animals that were immunodeficient. They could not reject skin allografts and could not produce effective antibodies to either sheep red blood cells or to *Salmonella* H antigens; immunological competence could be restored by a syngenic thymus graft. Meanwhile, Robert Good observed that thymic abnormalities in man were associated with immune disorders. These classical studies laid the foundation for modern cellular immunology, and demonstrated the central role of the thymus in the creation of a fully functional immune system.

The last decade has seen enormous advances in many areas of thymic research, and at a pace that may have left many feeling overwhelmed or bewildered. This new book provides a review of these discoveries, and helps to clarify an often confusing subject. Each chapter provides the reader with a clear and concise account of an aspect of thymic function, ranging from its structure and development to the generation of the T-cell repertoire. The book is well-illustrated and extensively referenced, allowing the reader to pursue the original papers. It is indexed well, and includes a glossary for those not *au fait* with the subject. Despite the wealth of information in the book it is still only 80 pages long, and it is a credit to the writers that its brevity has not impaired its clarity.

I can thoroughly recommend this book to anyone wishing to acquaint themselves with current thinking in cellular immunology. (It would be of particular interest to BSc students in immunology or pathology). It is very well-written and could easily be read by anyone with even a basic understanding of immunology.

K Pervin
Research Fellow in Immunology

Classifieds and Announcements

The *Gazette* is pleased to publish classified advertisements. These are charged at the rate of 10 pence per word—money with order please. It is helpful if you can include a contact telephone number in case of any queries.

Announcements of births, deaths and changes of address will be published free of charge.

Please ensure that these items reach the *Gazette* office four weeks prior to publication.

Edward Sealy Nicholson

Edward Sealy (Ted) Nicholson, who qualified from Guy's in 1939, died in his eightieth year in March 1992. He was an outstanding rugby football player, served with the RAF from 1940-46 and then entered general practice at Beccles, Suffolk.

Born at Bristol in 1912, Ted spent his childhood at Caterham, Surrey and was educated at Marlborough College and Wadham College, Oxford before entering Guy's Hospital where he qualified with his Oxford degree and the LMSSA in 1939. During the period of his house appointments at Guy's he married Joyce, a teacher, in Salisbury Cathedral and their first home was a flat in the George Inn, Southwark. In May 1940 he joined the medical branch of the RAF, served as a doctor in Training Command, reached the rank of squadron leader and was awarded the MBE (Military) for his services. Two years of his service were spent in Nova Scotia and his last posting took him to East Anglia as senior medical officer at RAF Horsham St Faith, Norwich. After demobilization he held an ex-service medical registrarship at the Norfolk and Norwich Hospital when he was approached to join a general practice at the Suffolk market town of Beccles in the Waveney valley.

In general practice at Beccles Ted was a round peg in a round hole. He had all the skills and qualities that make an outstanding general practitioner, his patients were devoted to him, and both he and his family enjoyed the life at Beccles in the Waveney valley. He undertook much obstetric work and gave anaesthetics for local dental surgeons and at his local general practitioner hospital, the Beccles and District War Memorial Hospital. Here, one of the surgeons with whom he worked was M (Michael) C Gilbert FRCS, Guy's 1949, who joined Ted's practice as a partner and was also appointed assistant surgeon to Lowestoft and North Suffolk Hospital as well as the War Memorial Hospital at Beccles. Ted did much for his local hospital, serving as Chairman of the Friends of the Hospital, and also the town of Beccles in many other ways. He was Founder Chairman of it's civic society, the Beccles Society, and served it as Chairman for over 20 years. He supported several local sporting clubs, including that for rugby football, as President, and, with his especial interest in music also served the local art society. He sang with his wife, Joyce, in the Beccles Choral Society and played the viola with skill.

A man with a rather sensitive and imaginative temperament, he had a charming smile and an attractive hesitancy of speech that was a legacy of a childhood stutter; he could nevertheless be firm and strong-willed when the occasion demanded it. In 1973 the Nicholsons moved from Beccles to the nearby village of Geldeston and Ted retired from practice two years later. In Geldeston he again served his community as Chairman of the Parochial Church Council and as Church Warden. In his many local activities he was always supported by his wife Joyce. She survives him together with their son, also a Wadham man and a teacher in Canada, three daughters and eight grandchildren.

Ted's prowess on the rugby football field, of which he would only speak with some reluctance in his later years, needs

its own paragraph. He was hooker for the Oxford University side in the four Varsity matches of 1931-34 and in club rugby he played for Barbarians, Leicester and Blackheath as well as Guy's Hospital. He played as hooker for England v Scotland, Wales and Ireland and against Wales and New Zealand in 1936 (5 caps). Ted captained the Guy's side in 1937-38 when H H (Gerry) Crabb was secretary and the team included two other international players: Louis Babrow, a Springbok, and Charles Dick who was capped 12 times for Scotland. Ted's fine tenor voice, that later supported the Beccles Choral Society, was much in demand for the singing that follows the rugby game and it is understood that his rendering of *The Little Red Rooster* brought him especial notoriety.

Guy's Hospital has produced a gallery of graduates distinguished both on the rugby football field and in their medical practice. Ted Nicholson was one of them.

ABS

Reunion of BDS 1971

On Friday 6 March, the less-than-casual observer outside the Glazier's Hall could not have failed to notice the steady arrival of a motley collection of men and women of definitely middle age, each one bearing a distinctively apprehensive air and perhaps the fixed smile of an examination candidate entering a viva or a dutiful visitor to an elderly and tiresome relative. Yes—all the hallmarks of an alumni reunion. A hundred anxieties barely beneath the surface. How old would everyone look? Worse, how old did we look? Had we forgotten all the names of our erstwhile student colleagues? Would they fail to recognize us? Is the toupee on straight? Does the Grecian 2000 show?

A minute inside the Hall would, however, have dispelled this picture with magical ease, to be replaced by all the sights and considerable sound level of 50 friendships being renewed with genuine pleasure. The venue was excellent, the buffet superb, the drink reviving after a long journey. Honours for the longest journey were probably shared between Jim Tennant, Sophie Cheevers and John Novak, all from over the Pond. Thanks for the organization must go to Tom Pitt Ford and his newly arrived secretary for faultless execution of what was undoubtedly a great idea. And how thoughtful of Tom and Mike Gleeson from amongst our number to remain working at the *alma*

mater and be on the spot for ease of logistics. It seemed better 20 years after qualifaction than 10—the last such reunion. We all seemed happier, more interested in each other's life and times and less distracted by making an impression, or money, or the tribulations of work. Perhaps life does begin at 40—and there seemed plenty of it left in the old dogs yet; 3am found a large quorum still up and talking in the bar of the Tower Hotel and the next morning was an endless breakfast from a respectably early hour. All in all, a format to be repeated, and since older occasionally does mean wiser we aim to make it only a five year gap-not 10.

Roll on the silver anniversary and for those who couldn't make it, phone Tom now and reserve your place.

NWTH

Over educated?

In earlier times education was deemed 'wasted' if it was offered to the lower orders, and especially if these were women. Only those with apparent inherited intelligence, which it was thought accompanied the position in the class pecking-order, were entitled to higher education of any form. This enabled the class structure to remain somewhat stable. The National Schools, established just over a century ago, offered teaching by rote in the 'three Rs'. Thus both industrial and society needs were served, and in the words of the old familiar hymn, *All Things Bright and Beautiful*:

The rich man in his castle
The poor man at his gate
God set them in their station
And ordered their estate

Nowadays lots of folk have rejected the idea of both God and the class system, but in years gone by the situation was typified by George Eliot's description in *Brother Jacob* of one of the characters: 'I fear she had been rather over-educated for her station in life ...'.

Edmund Leach, Provost of King's College in 1969 asserted, tongue in cheek that we should stop educating women like second class men, because it was 'getting too difficult to get anyone to do domestic chores'. Fortunately there had been others long before, amongst them Mary Wollstonecraft, with a call for education which gave an individual 'mature self-fulfilment'.

Although all this may be a little behind us now, it was strange to hear certain views expressed on the eve of this year's Royal College of Nursing Conference at

Blackpool, in a programme on the wireless. The wireless itself may appear a somewhat dated instrument of communication, which had a queer sounding name to my ears as a child. Of all the household appliances, the one with the most wires was known as the 'wireless': for it had not only an attachment to the mains, but also an aerial and an earth—all wires. Wire-less!

However, to return to the broadcast, it was suggested that nurses may be over-educated and over-paid for the task for which they are employed. So many nurses have degrees nowadays, myself I must confess amongst them, but what need have we of this high-powered background to care for our patients? In this radio programme a traditionalist, in the form of a consultant surgeon, was wheeled out to state the obvious: nursing is a simple job, which only needs a straightforward training, a kindly person, and does not require extensive knowledge, such as that offered in the course of obtaining a degree. One wonders if such a surgeon, in the stillness of his life, whether he cherishes the idea of simple girls caring for the sick in their beds. The image of angels mopping fevered brows, rather than the ardent young career woman or man, often encourages this kind of thinking.

I don't intend to defend the idea of higher education for all who will aspire to it. I take it as read that it will improve the quality of life for those who obtain it, and those surrounding may benefit. It is nice to know that the Health Secretary, Virginia Bottomley, said prior to the RCN Congress: 'I certainly don't accept that the majority of tasks can be done by less skilled staff, neither do I think that what nurses do is perform simple tasks. Nurses have a formidable knowledge, skills and training and the challenge for all of us is to make sure we use those nurses as well and as effectively as we can'.

Nevertheless it is of concern that those who deplore over-educated nurses also consider them beyond their station both in pay and position. In the broadcast already mentioned, one speaker hinted that nurses may price themselves out of a job. The reasoning went somewhat thus: if employers can recruit staff with only a little training to carry out nursing tasks then they will do so if this costs less. In the market economy, of which we hear much, the return is all that matters. And does it need 'over-educated', expensively trained, highly paid nurses to care for the sick, when others with less attributes can perform the task? It is a question which needs addressing, and a search for an answer sought.

There are often, as in so many aspects of life, more questions than answers. I always remember a group to which I belong once holding a meeting entitled, 'Your answers questioned'—the clever printer assumed this was a mistake, and promptly corrected it to 'Your questions answered'; such is the conventional wisdom. The arrival of a rival to the *BMJ*—the *BNJ*—the *British Journal of Nursing* is an indicator that nurses are now taking a more professional approach to these questions. The difference between either the *BMJ* or the *BNJ* is smaller than both from the *Nursing Times*. But if you are using these abbreviated forms over the telephone, then the difference may only be clearly noted if you annunciate whether you mean the 'monkey' or his 'nuts'.

Denis Cobell

Exams sweet exams

At this time of writing, many years ago, I was writing the final exams of the Chartered Society of Physiotherapy (CSP), and then came to the practicals. We received a ticket recording our time and number—which we pinned to our chest—and turned up in trepidation at the examination halls in Queen's Square. We had been there before—as models in our first year for the interim and final exams of others; also for ourselves—for the anatomy viva of 'prelims' at the end of 18 months of training—for the practicals of 'interims' at two and a half years, of massage, electrotherapy and remedial exercises—and finally for 'finals'. One had a long case and a short case. Although related to time, these were not types of antique clocks, nevertheless we were certainly wound up enough. My long case was a cauda equina lesion and my model was the largest and heaviest student I had ever seen, who came from St Thomas's. Dr Cooksey was the examiner and reclined throughout in a deck-chair.

There have been many changes since then. Indeed most courses are now validated by the CSP rather than set and examined by the Society and most are degree courses. The practical component passed through the phase of assessing real life patients, who kindly gave of their time and their disability to go through the 'process'. The Guy's course changed from this form into the present form of requiring a pass in every clinical placement throughout the training. This change has inevitably put greater responsibility on the senior clinician who is supervising the placement as pass/fail decision has to be made by him or her. There is a clinical tutor from the school who is always available for discussion who becomes involved to a greater extent in any questionable situation. Students who do not pass the placement are required to do the placement again. If the student does not accept the decision there is an appeal process. In Guy's this process has been activated on two occasions.

The other day a lady came into Shepherd's House as she was in the vicinity after many years absence. It transpired that she had been a student in Guy's in 1941 when the training was in two parts. Massage, movement and gymnastics (CSMMG) and then light and electrotherapy (LET). She was delighted to look around and although the Light Department was now the Boiler House (the carbon arc lamps have been superseded by the ultra-violet lamps which are upstairs); although the long-wave and short-wave machines are no longer in mesh caged rooms and have been replaced by pulsed short-wave and the miscellany of modern invention—such as ultrasound, interferential and laser; although the men's treatment room is now the Rheumatology Clinic, she was surprised to recognize the Physiotherapy Room to be almost exactly as it was when it was the women's treatment room. The only difference being that there are fewer wall bars and each treatment couch is curtained into an individual cubicle.

Enough of reminiscence. Our remaining students wrote their final exams in June, having completed the practical placements of the course by 5 June. At the time of writing the results have yet to be published on 10 July with the school cake in the Roben's Suite the day after, at which I hope our erstwhile visitor will continue her reminiscence.

Diana Innocenti

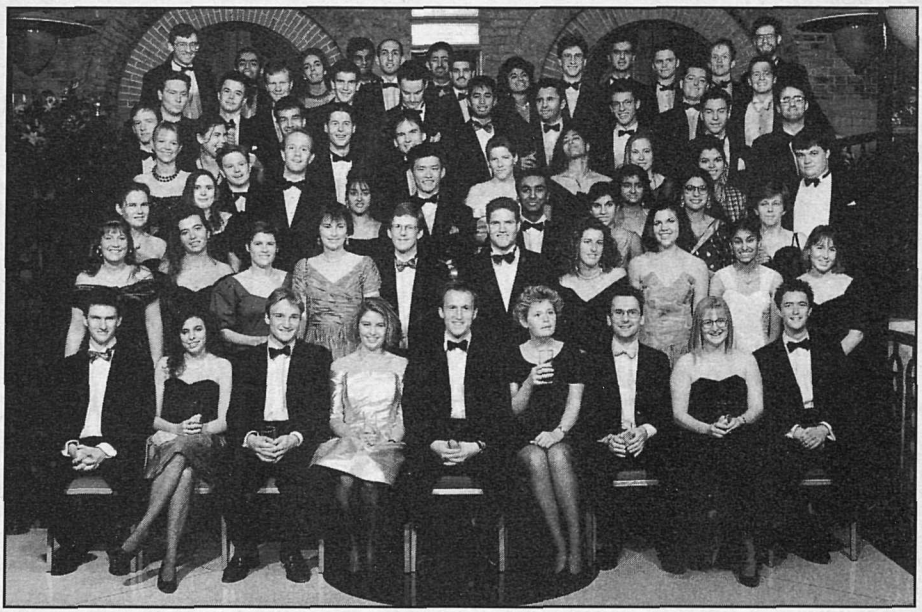
Final Year Ball 1992

The venue for this year's Final Year Ball on Saturday 27 June was the Whitbread Brewery in Chiswell Street, EC1. A definite success, it was attended by most of the Guy's final year students, plus members of staff from Guy's and Lewisham medical and surgical teams.

The evening commenced with glasses of Pimm's all round, and once the Final Year Photo was taken, then it was into the Dining Room for the dinner. A splendid meal of three courses, including ample wine, was served promptly and enjoyed by all.

The after dinner speech delivered by Mr Bill Owen was well received; being full of amusing quips and fairly short it seemed to hit the right spot, though some were surprised that there was no mention of the late Mr O'Flynn, originally billed to deliver the speech and who was a significant support to so many attending.

Vigorous dancing followed to the tones of the Jazz Band 'Jeepers Creepers' interspersed by music from the disco and—judging by the numbers and enthu-



Final Year Photo 1992 (Photo: PKW Photography)

siasm seen on the dance floor—this choice of music was met with general approval. The floor was alive with people wriggling and jiving but the prize for 'dancers of the evening' must surely be awarded to the dynamic duo from Lewisham Hospital—Doctors Mallinson and Jackson!

Overall, it was a great evening, and widely enjoyed, though the abrupt end to proceedings at 1am left most of the dancers hungry for more.

Lastly, many thanks to Bill Owen for his speech, and to the organizers (Ruth Prosser, Clare Fouque, Guy Selmon and Ian Francis) for their hard work in making such an enjoyable evening possible.

MS

UMDS Men's Hockey

Past v Present

This year the Past versus Present match took place on the astroturf at Battersea Park. The weather was rather warm and even though most sports fanatics were busy involved in armchair viewing—it was that time of year—we decided that a good clean game of hockey was the order of the day. The idea was a nice thought but practically it turned into a sadistic form of torture.

The match commenced with the umpire (Abhi) calling all parties concerned together and asking them for a friendly match with no blows below the belt. Those present agreed to this but there were a few sly smiles from the likes of Gill, Ong and Cynk. Play began with quite a show of artful skills from the Past and the Present's hope of a slow pace was soon shattered as Cynk managed to score a goal at such speed that even his new MR2 was impressed! The Present soon replied with a good effort by Russell and Hayward culminating in a typical Colin-like finish. The first half was seemingly endless and the players began to beg the hobbling umpire to blow the whistle which he did with much glee.

The interval lasted for a good 20 minutes of which most was spent quenching thirsts and muttering about team tactics. The teams restarted play and after 10 minutes Mr Spencer (the retiring Presi-

dent) left with many apologies and the excuse of having to attend a meeting. From then on the Present started to flag as Black (also an MR2 owner) and Cynk added another three goals to their tally. The pace was now quite sedate with the Past beginning to show their ages and the Present starting to show their unfitness. The final whistle blew to the relief of all and this concluded an afternoon which would have tested the tolerance of any sane individual. We all reconvened in the Shoes for a few social drinks promising to have next years fixture earlier and thus under less gruelling conditions.

I would just like to finish off by thanking Mr Spencer for all his hard work in supporting the club together with Bob and Eric for looking after the pitches at Cobham and HOP respectively.

Abhi Lall

UMDS Netball Club

UH Cup report

The UH Cup was looked forward to with great anticipation. Eight hospitals took part and were formed into two groups of four. We came top of our group beating the following: Mary's 11-7, George's 21-7 and King's 25-1. We then went on to play Charing Cross (runner's up in the second group) and beat them 14-7 and then began to formulate a game plan for the final which was to be against UCH. The final began with a lot of cheering from the hordes that came to watch us play at HOP. Thankfully the team played together very cohesively and with the goal-shooting skills of Melanie we managed a resounding victory of 24-6. We were then presented with the Cup courtesy of the Medical Sickness Society together with medals (Medical Protection Society) and then tucked into refreshments supplied by the Medical Defence Union. After this, we met later to enjoy a very festive night.

I would like to end by thanking Eric for all his hard work, the supporters for their vigorous cheering and I hope that our victory encourages more people to join the club next year.

Team: Melanie Buck, Nicola McDonald, Kate Scanlan, Julia Jefferson, Katie Powell, Alison Currie, Louise Wells, Iddi Bickell.

Ali Currie

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Death

GODFREY Laurence Walter, Guy's 1944, died on 12 May this year from cancer at the age of 69. He was born on 25 December 1922 and was consultant orthopaedic surgeon at Stoke Mandeville Hospital until his retirement in 1988.

He leaves behind his widow, Joan, four children and eight grandchildren. He was a contemporary of Professor Ian McDonald and was awarded a gold medal in surgery.

Guy's Hospital — 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number is available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital — 250 Years, Guy's Gazette, Boland House, London SE1 9RT.

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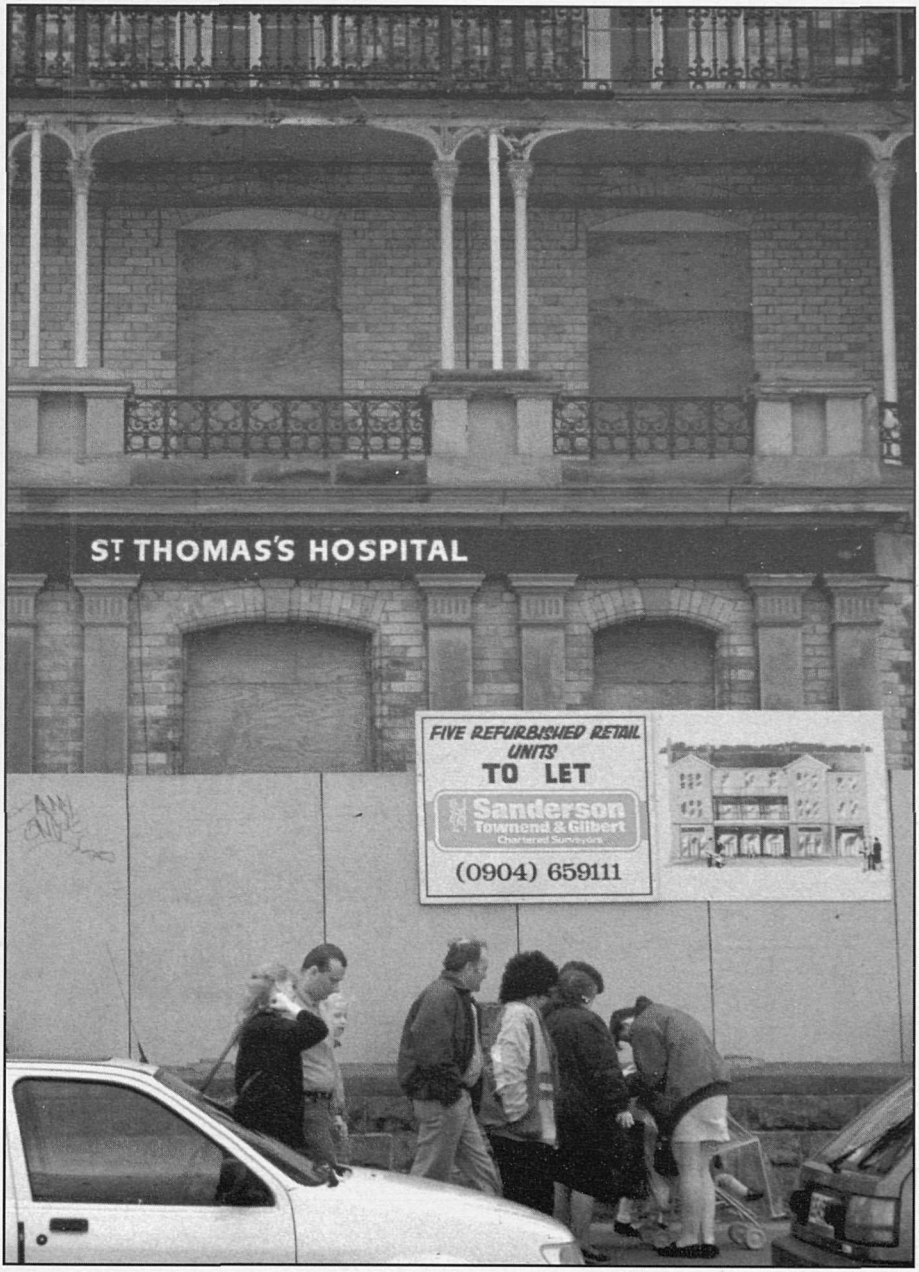

A £10 prize will be offered for the most original and funniest caption to be received by 15 September. The editor's decision is final.

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GUY'S HOSPITAL GAZETTE
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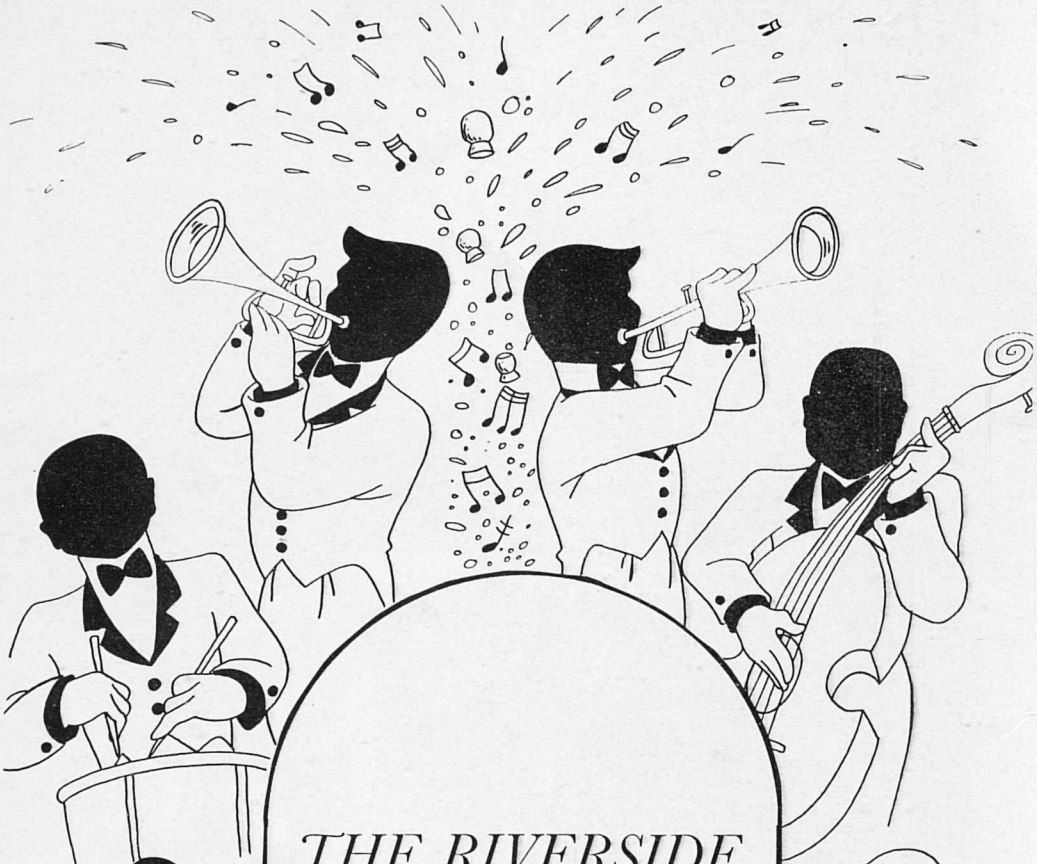

THE RIVERSIDE BALL

in aid of

THE BRAXTON HICKS FUND

at Guy's Hospital

FRIDAY, SEPTEMBER 11th, 1992

HAY'S GALLERIA,

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Guy's Gazette

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Passim

Following the graduation of many students in July, next month we may look forward to the arrival of another batch of Fresher's to take their place in the numbers at Guy's.

Those who have just left Guy's were preclinically taught on one campus, gently introduced to the other clinically, and saw the beginning of the split-campus teaching of their juniors. Over this time even the traditionally fierce rivalry of the clubs has been overcome sufficiently to create new teams and societies. With the wind of change once again gathering momentum at Guy's, who knows what changes will have been witnessed by those enjoying the fun and frolics of fresher's week by the time they qualify. The everlasting verbal battle—between those who see prospective changes as a threat to the ancient timbers of Guy's and those who see it as a chance to blow away the cobwebs—will continue to rage. If there is any foundation to the dark rumours circulating about the future of Guy's and St Thomas' (pending the findings of the Inquiry into London healthcare), the looming merger with King's may be the least of our worries about the future.

The wind of change has even blown a draft under the Gazette door. From the production of my first Gazette to my last the tools of our trade—paper, glue, scissors and much red ink—have been exchanged for a computer, mouse and printer. I have greatly enjoyed my time working on the Gazette and would like to take this opportunity to thank those who have been so helpful, particularly Margaret Flanders and Fuad Hussain, and Dr Knight.

I would like to end by congratulating those who have just passed their Finals, and wish them every success in their future careers.

Guy's Hospital Biennial Dinner

Dear Sir,
Can I take this opportunity of reminding all readers about the Guy's Hospital Biennial Dinner to be held on Friday 2 October, at the Connaught Rooms, Great Queen Street, London WC2, at 7pm for 7.30pm. Mr Hugh Kinder has agreed to act as Chairman for the occasion and already over 200 people have subscribed to come. However, there are still plenty of tickets available and we particularly welcome group bookings for those who would like to be placed together at the Dinner. All those interested should contact Barbara Ingarfield at the Clinical Superintendent's Office, Guy's Hospital, tel: (071) 955 4169.

Yours faithfully,

MARTIN JOURDAN
Honorary Secretary

Sweet Tooth—correction

Dear Sir,
Much as Physiotherapists like cake for tea, it was not on offer at the closing down occasion on July 11th. Although a special School cake would have been appropriate, the event mentioned in the July *Gazette* was the School *wake*.

Yours faithfully,

DIANA INNOCENTI
Physiotherapy Correspondent

All in a name—or not?

Dear Sir,
We note with interest the *Gazette* feature concerning Rag Week 1992 (July 1992)—no, Rag Week not Charities Week again—that one of the Trust Managers found the Rag Week logo too unsavoury to be displayed on the Tower. We find this somewhat surprising—but what surprises us even more is that he allowed the word 'St Thomas'' to spoil an otherwise eloquent and informative notice. Surely he must realise that blatantly advertising the name of our 'rival for survival' in South East London, despite Guy's obvious supremacy, may have jeopardised the future of the Trust in which I am sure he plays a major part.

On a similar note—surprise turned to absolute astonishment on reading that Mr Simon Argles, not content with obliterating the name of Guy's from the title for the Medical School that he proposes—but also he suggests that we be branded under the name of King's College. May we urge Mr Argles to think and not to cast aside such a famous name as Guy's—and also St Thomas', if that is what it takes to preserve the name of our great School and Hospital.

Dare Quam Accipere,

Yours faithfully,

J G COOMBES
S E R PRYKE
Boland House

Smokey Surgeon

Dear Sir,

J H Pitt-Payne has some doubts (*Gazette* June 1992) about the story of Lambrinudi smoking while operating in the days of open ether.

He certainly did so at the plastering stage, as it was pointed out to me that his patients could always be identified by the cigarette ash incorporated in their Plaster of Paris bandages.

Yours faithfully,

Dr P N CARDEW
Rushton Farm House
East Stoke

Park Rededication Service

Park Rededication Service

At a service on 22 July 1992 the Park was rededicated following numerous improvements and relandscaping over the last few months, courtesy of the Special Trustees. The service was taken by the Reverend Neville Smith and the new plaque unveiled by Mr Peter Winfield (Special Trustees of Guy's Hospital).

Physiotherapy Fellowship Awarded

Ann Hunter, Director of Therapy, has been awarded Fellowship of the Chartered Society of Physiotherapy, in recognition of her advancement of the profession. Her work has been in the areas of quality assurance and audit.

New Director of Facilities Management

Graham Perry, formerly Director of Estates and Support Services, at York Health Services Trust, joins Guy's and Lewisham Trust this month to head a range of existing directorates and support services; these include Commercial Services, Projects, Works Department, Porters, Cleaning and Security.

407 Art Club

The 407 Art Club is planning an exhibition of drawings, paintings and photographs on the theme 'Guy's Hospital and Southwark'.

Staff members, students and friends are all invited to submit their work by 15 November 1992. The show will take place at Guy's in December.

New Chairman for Friends

At the Executive Committee Meeting of the Friends of Guy's Hospital on Thursday 2 July, we are happy to announce that Dr G W Scott has been elected as Chairman.

CPR refresher courses are essential

This is the verdict of a study of Consultant's skills in giving CPR. Of 24 Consultants at Bedford General Hospital who were asked to demonstrate resuscitation skills, none were judged 'adequate' when measured against a standard laid down by the UK Resuscitation Council. Authors of the study said that the solution to this worrying situation was to have regular refresher courses. After 2 hours training most of the Consultants scored maximum marks.

Medicine—the Do's and the Don't's

The Art of Happiness

In this, the final part of his 1921 lecture to the students of Guy's, Sir Alfred Fripp expounds on the importance of one's attitude to patients and colleagues—for the happiness of self and others, and for success in medicine and life.

'The Art of Living'

Let me get on to a short list of 'don'ts', which apply to all branches of practice.

Don't frighten people by making a dangerous diagnosis at the first interview—unless it is to the detriment of the patient to wait until tomorrow.

Don't interfere outside your job if you can possibly avoid it.

Don't give the patient just so long to live, you may be wrong, even the youngest among us is not omniscient.

Don't forget that they are all patients, which means ill people, and therefore not their normal selves.

We are all told there is no such thing as a normal man or woman—there is only average. Too much variation from the average justifies the expression 'abnormal'. No two patients are alike, no two doctors are quite alike, there is always the personal equation, and no two cases are quite alike either. Hence a large share of the charm of our daily work. It is never really monotonous—whatever the class of practice that falls to your lot.

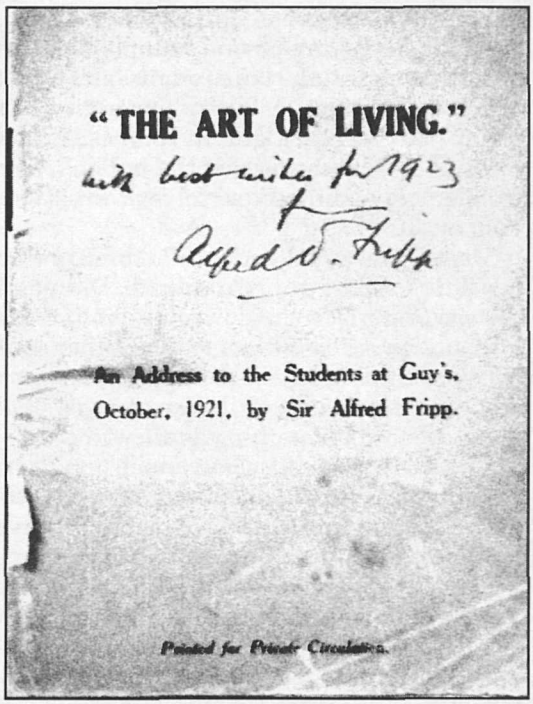
So whenever you pay a visit, don't leave the house until in one way or another you have made them feel they have had their money's worth of you, which they won't if all you say is, 'I will see the patient again tomorrow'.

As far as possible keep your eyes and your ears open and your mouth shut, and then you will avoid that troublesome complaint which George Eliot dubbed 'logorrhoea,' and you will note and banish from your conduct the points that raise a laugh when a doctor is personified on the stage. The theatre is the best of all post-graduate schools for us doctors.

'It's not the man who knows the most as has the most to say.

It's not the man who has the most as gives the most away.'

Nearly 50 years ago an early worker in the field of tonsils and adenoids published a book entitled, Shut Your Mouth and Save Your Life. It is a pity it has been forgotten, for its mere title, by inculcating a good habit, saved many a child from developing trouble which necessitates operation.



The original transcript of the Lecture, circulated in 1921.

Patients will leave you and go into the camp of your rival—and for many causes—mostly trivial and unreasonable; often the explanation is surprisingly simple and natural. Oddly enough, incompetence is the rarest of causes. Such, and other, disappointments must occur to each of you. Don't let them worry you or make you the prey of the yellow-eyed monster jealousy, but keep a stiff upper lip and play the game. The days have quite gone by when there was an excuse for the idea that any doctor has any proprietary right in any patient.

Others leave your rivals and come to you; and for no better reason, so don't get a swelled head! Everybody has either had his bump or is just going to get it! Be magnanimous to your rivals as long as they are straight. It is an old saying that prosperity is harder to face than failure.

Do we always remember that doctors are made for patients—not patients for doctors? Are we not rather close-minded as a profession? Are we not rather too apt to think that our orthodox textbooks contain everything it is good for us to know, or for the public to have any recourse to? Are we quite proud of

the attitude our profession has in the past adopted towards any advance in the methods of doing good brought forward by the unorthodox, for example, the homeopaths, the bone-setters, and the other'healers'? Have not we sometimes taken rather a 'worm's eye view' (as an American friend dubbed a certain lady's autobiography) of these matters, and has that attitude increased our standing in the eyes of the public? And would it not be better for us and for them if we showed ourselves willing sometimes to get the beam out of our own eye first?

There is always a tendency to think one knows better than others, or at least has little to learn from experience. Didn't somebody call this attitude of mind the airy complacency of ineptitude?

Try to avoid self-satisfaction, rather look upon *every* fresh experience as being of importance. The capacity for assimilating what is useful from his environment is one of the greatest essentials to success in our profession, therefore think of nothing as alien to you.

Do we always realise how much good or how much harm we can do to each patient by our words, by our manner, even by our countenance? Every patient feels better or worse for having seen his doctor—and he hopes to feel better—unless he belongs to that comparatively small class that 'enjoys bad health'.

Every patient is, in fact, in a receptive or suggestible condition, and a sacred trust is reposed in you to make the effect upon him of your presence productive of as much benefit to his case as possible. As an instance do not be swept off your feet by the modern craze for putting almost every case into bed and investigating it minutely and at great length. By no means omit to carry out any of the up-to-date examinations clearly necessary for forming an opinion upon which advice can be safely founded. But discriminate, don't overdo it. Many a patient has a tendency to introspection, especially when classed with others who are more ill than she is, and many so situated have either felt impelled to court the pomp and circumstance of an operation or have emerged from the up-to-date clinic confirmed psychopaths. It is a notoriously difficult job to unscramble an egg.

Courage, industry, concentration and devotion to your patients' interests will carry your interview further than all the talents.

With each and every patient your interview is a crisis in his day, if not in his life. So no complaint that incommodes is 'trifling'. I believe it was Gull who said, 'A pimple on his nose is more important to him than a cancer on his neighbour's thigh.'

Finally, the higher you rise the more people can see you to fling mud at you. Few are able to carry success without some friends discovering symptoms of

a swelled head, but I hope you may achieve the one without the other, and that 'as you go up the hill of prosperity you may never *meet* a friend'.

It is certain, however, that success cannot come to all of you, nor can you all keep your health; but happiness is within everybody's grasp, whether he is successful or not; even whether he is healthy or not. Many of the greatest invalids have been happy and have radiated happiness to others. It is almost entirely the individual's fault if he is not happy, for happiness is a cast of mind, and it can be cultivated. One of the greatest lines of the greatest of all poets says, 'There is nothing either good or bad [in this world] but thinking makes it so'. Happiness resides not in the pocket nor even in the bodily health, but in our mental attitude to our surroundings and in contentment with our lot. We cannot entirely govern our surroundings, but each of us is captain of his own soul. Thank God for what you *have* got. It is quiet easy to be wretched though rich and healthy. There are several ways, but the surest of all is to permit yourself to feel jealous of others for having got something you have not. I would go so far as to say that among all the really rich people I have met, I have rarely met a really happy one; far more often have I met contentment and happiness under straitened circumstances. A wealthy man once said, 'You may own a quarter of a million, but half a million owns you.' And, further, it is an open question whether too much success, like too much money, is not fraught with such anxiety and distrust of others as to spoil its owner's enjoyment. The more worldly forms of success are often far removed from happiness.

Happiness, indeed, is an art, and like all arts it requires fostering by practice till it becomes a habit—and any man or woman may acquire it, though perhaps not all to the same extent.

Happiness is satisfaction constantly renewed which is a very different thing from satiety. If you can attain happiness you will find that all else is added unto you.

Thus ended the address—no doubt Sir Alfred Fripp would have heartily approved of the sixth term Sociology and Psychology courses!

FFH

The KEM Hospital

India on a shoestring

It is difficult to write about India without seeming to sound clichéd—especially for me since a cliché is almost the limit of my literal ability—but India is an assault on the senses. It reaches out from every street-corner and is filled with unforgettable images. It is a magnificent country that will leave you a changed person—you will either love it or loathe it. I spent 16 weeks in India as part of my elective and, fortunately, I loved it.

The first 12 weeks were spent in Bombay. Bombay is unlike other parts of India; it is a city obsessed by money and every man is measured by his wealth. It's inhabitants live at opposing ends of the spectrum of affluence, and the poor are daily reminded of their poverty. The rich in Bombay live on Malabar Hill in the worlds most expensive real estate—an apartment here costs more than one in London, Paris or New York! They have cooks, servants and a chauffeur to drive them to their clubs (a remnant of the Raj) to chat, swim or play golf. The poor sleep on the streets and possess nothing.

My elective appointment was at the King Edward Memorial (KEM) Hospital. It was built at the turn of the century and is in Parel, an industrial suburb of Bombay. The KEM is one of 4 or 5 municipal hospitals in Bombay. They are government-funded and serve the majority of the population. From the outside, the KEM appeared clean and sturdy, and there was a well-kept lawn in front of the steps that led into the main hospital. Inside, it was more like a railway station than a hospital. The high-ceilinged entrance hall was awash with people, many were queuing for entry to a clinic, some just sat on the floor, others were begging. Everyone seemed to be shouting, it was very unlike the furtive whispering of waiting rooms at Guy's. At first sight it seemed chaotic, but there was method to the madness and everyone eventually saw the appropriate doctor.

My first weeks were spent in the department of paediatrics, and the first child I saw was in out-patients. She was about five years old and had been feverish for a few days; now she was refusing to drink. There was a bite mark on her upper arm. Her parents confirmed that a dog had bitten her a couple of weeks ago, but that it had not seemed serious and that she had been well since. The child had rabies and was dead by the following evening.

Hundreds of children were seen that afternoon. The doctor sat behind a couch and struggled to hear the history over the noise of the clinic. The examination was brief but thorough; they were each armed with a stethoscope, a large metal torch, a wooden tendon hammer and their extraordinary clinical acumen. They elicited a battery of signs (each with its own eponym) about which I had never read, let alone seen. It was a dazzling exposition of the art of medicine, and was to be repeated throughout my time at the KEM. It made me realise how much I had begun to rely on investigation rather that examination, and in many ways that was the most important thing I learned in India.

The paediatric wards were housed within a newly constructed part of the hospital. They were relatively clean but spartan; the parent was allowed to stay with the child and they were encouraged to bring food with them. A charge was levied for in-patient care and although it was only the equivalent of about 10 pence, it represented a considerable amount of money to most families. As a result both children and adults were often very ill, sometimes terminally ill, before attending hospital. This problem was exacerbated by the fact that most Indians visit their 'general practitioner' in preference to the hospital. Unfortunately, these 'general practitioners' are often not medically qualified so patients often part with their hard-earned money but receive no effective treatment or advice in return. I well recall a 10 year old boy who had fallen from a wall. He had a bruise the size of a hen's egg on his forehead and had complained of feeling slightly dizzy. His father took him to the GP who prescribed some tablets. Subsequently the child had become drowsy and confused, and as his condition had not improved his father finally brought him to hospital. The GP had prescribed the child an adult dose of phenytoin, and once this was stopped the dizziness and drowsiness abated.

The adult wards were in the original hospital building. They were dark, dirty and ill-equipped. Cats roamed the building, presumably in an effort to keep the rodent population to a minimum. Unfortunately they had no effect on the cockroaches. There were about 50 patients on each ward; some had beds, others slept on mattresses on the stone floors. There were large numbers of patients with TB, malaria and rheumatic heart disease—and often combinations of all three. Many were also alcoholics, suffering from cirrhosis. Hooch (illegally distilled alcohol) is quite common in Bombay, and the newspapers often carried stories of 50 or 60 men dying from methanol poisoning after an evening's binge.

The formulary was limited, and many drugs had to be paid for by the patient. This presented a problem in treatment, as some patients could not afford to pay. It was a dilemma often resolved by the doctor donating the payment.

My abiding memory of the KEM is of doctors working tirelessly for their patients in very difficult conditions. It must have been very frustrating for such well-trained doctors to have been so limited by a lack of resources. Nevertheless they were unstinting in their efforts to help their patients. They were also very friendly to elective students and would find time in their schedule to explain a case or translate questions to patients (the notes are, incidentally, are written in English). The Indian health service only continues to function because of the selfless efforts of its junior doctors. They work up to 100 hours per week, live in dismal hospital accommodation and yet in Maharasthra state they are paid the equivalent of just £50 per month—even in India, and especially Bombay, £50 does not last long.

And now there is a new enemy: HIV. The World Health Organization predicts that in India the 60,000 people already infected will require hospitalization before the middle of the decade, and that by the end of the century, if current infection rates are maintained, it will have the largest HIV-seropositive population in the world. This will deprive the country of its workforce, negate recent gains in infant and child health, and place an intolerable burden on a health care system that suffered a budget cut of 10% in 1990.

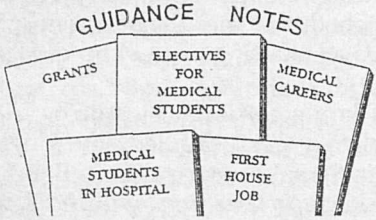
Things, it seems, can only get worse.

TAP

To all Guy's Staff

If you have any news items from your departments which you would like us to print in the *Gazette*, for example important research, fund raising, awards, retirements, new staff etc, please feel free to drop us a line on ext. 5413.

We look forward to hearing from you!



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An Indian Odyssey

How not to begin an elective

He repeated, 'No, Sir'. It was midnight in Bombay, and still hotter than an English summer, as we watched nine months of careful planning unravel. It had all seemed so easy, chatting over a cup of Darjeeling in the Spit.

The adventure had begun about 24 hours earlier at Heathrow. After the inevitable delay and an anxious farewell to a rucksack filled with four months worth of toilet paper (entrusting Alitalia to make it re-appear in Bombay), we were airborne. Unfortunately we were back on *terra firma* within a few hours for a stop-over in Rome. It was midnight. In fact. during the course of the elective, irrespective of our destination we always seemed to arrive at midnight. The airport was deserted, apart from an insistent taxi-driver with an electronic voice transducer. He pursued us through the echoing corridors with a bizarre voice that seemed like a talking lift impersonating Don Corleone.

Finally we arrived at our hotel, but to find the bar shut and that room service did not exist. Our plea for drinking water resulted in directions to a throbbing nightclub further along the road; realizing that the handful of lire kept from previous holidays was not sufficient for a tip, let alone a drink, we retired for the night. A long discussion on whether Roman tap water posed a greater threat to our health than imminent renal failure was followed by a few fitful hours of sleep.

By dawn we were back at the Aeroporto Leonardo da Vinci to ensure that our flight had been delayed—it had, of course. We were eventually on our way again, and after a very long 10 hours during which I lost all previous respect for Italian cuisine, we touched down in Bombay.

The pleasure of arrival was tempered by anxiety about the luggage; the ageing carousel noisily lumbered into action, struggling in the heat. Suddenly, almost unbelievably, the two gargantuan ruck sacks hove into view. Happily reunited with our mobile pharmacies, we rattled off to hire a taxi to take us into Bombay. The journey was to prove unforgettable.

The route from the airport takes one through the centre of what is reported to be the worst slum in Asia—quite a claim when one considers the poverty endured by that continent. The road was lined with shacks literally built from rubbish; fires eerily sihouetted the figures within. Most people, however, just

slept by the side of the roads. Whole families, indeed whole generations of families, lay asleep at the roadside; some were on pieces of cardboard but most slept flat on the hard-baked earth, with no bedding and few clothes, their arms crooked under their heads. They appeared to have no possessions. Bombay has been an economic magnet, the Indian city with streets paved with gold for the past 150 years; it is a city bloated by uncontrolled migration. Sadly, the slums and homelessness are not new. Mark Twain visited Bombay in 1896 and wrote the following: 'We arrived to move through a city of the dead. There was hardly a suggestion of life in those still and vacant streets. Even the crows were silent. But everywhere on the ground lay sleeping natives—hundreds and hundreds... Their attitude and rigidity counterfeited death'.

The journey from the airport is a shocking introduction to India. Later in our travels we were introduced to an American lady who had met her Parst husband at Harvard, had married him aged 19, and had lived in Bombay for the past 40 years. Friends of hers, she told us, had flown straight back to the USA after this shocking baptism. She thought the slum should be walled off because the stories of it deter so many travellers. We asked her if she ever missed America. Her reply, in its own small way, was as tragic as the slum: 'Every second, of every minute, of every hour, of every day.'

The taxi motored on into the heart of the city. Taxis were a continual source of amusement during our time in Bombay. All Indians, no matter how calm they may appear, are transformed into reckless, slavering madmen when they sit behind the wheel of a car. They weave between those lanes, elbows on the steering wheel as they struggle to light a cigarette; the air is filled with the noise of blaring horns. As a passenger, it is rather like watching an arcade game—the driver puts his rupee in the slot, then pushes the accelerator to the floor and spins the wheel to avoid cars, cows, cyclists and pedestrians. At night, headlights are only ever switched on to signal annoyance at other drivers.

A further hazard of travelling by taxi were the beggars. They would risk life and their few remaining limbs to reach the cab. If we stopped, even for a moment, a stump would be thrust through an open window, to be followed by a cry for *baksheesh*. I realise that the passage above sounds callous, but whilst in India I was surprised at how quickly the extraordinary became just ordinary. After a few weeks I stopped handing rupees to every beggar. I started to walk past the empty outstretched hands of children. I began to ignore them, in the same way that, perhaps, you have become used to the regular sight of beggars on the stairways that lead from London Bridge Station to Guy's. I was frightened by the speed with which I had become resistant to so much suffering. On my return home, I salved my conscience with a donation to a charity I had seen at work in India.

Anyway, the taxi eventually brought us to what we hoped would be home for the next 12 weeks, the WIAA Club, Malabar Hill. We longed for sleep's sweetly narcotic embrace. We were carrying almost as much correspondence between the club and ourselves as we were toilet paper, yet, of course, there was no record of our reservation. It was confusing at first because in India to gesture 'no', people rock their head from side to side (as if trying to shake water from their ears), and it looks very like an English nod for 'yes'; it was initially difficult to reconcile his insistence that we had no reservation while he continued to vigorously nod his head. It was time to use the communication skills that we had acquired from five years at Guy's. Our tearful pleading soon broke him, and he allowed us to spend the night in the television room. We smiled men-of-the-world smiles, thrilled at the brilliant ways in which we had overcome adversity—we were travellers, pioneers, *not* tourists. At that moment a huge rat that would have made a rottweiller whimper scurried across the floor. We lept into each other's arms and agreed that we had come away on elective by mistake.

TAP

Guy's Hospital — 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number is available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital — 250 Years, Guy's Gazette, Boland House, London SE1 9RT.

Senior Medical Ward Clerk—1969

Asthma, adrenaline and antics

Dr Ralph Kauntze, cardiologist and Consultant Physician to Guy's Hospital, had been around a long time - as had Dr Charles Baker who had been elected to the staff a year before him. I was on the Mann/Scott/Clark Firm. However, one story permeated throughout our year and that was the time someone got to Dr Kauntze's stethoscope before he did. Dr Kauntze was a gentleman in the true sense of the word, a man who radiated an old-fashioned courtly charm and tended to expatiate at great length on murmurs, thrills, weird rhythms, gallops, and yards and yards of ECG read-outs which floated through his fingers whilst the words poured from his mouth. What fun it would be, thought someone, if they were to totally block his stethoscope just before one of his ward rounds. Somehow, this was done and a check was made to make sure that no sounds at all were conveyed up the apparatus. I should add that he tended to use whatever was handed to him on a ward round because he did not carry a stethoscope about his person. The joke fell flat though, because he went through all the motions of listening with the stethoscope in question and then described the murmurs, thrills, and what-not with his usual dazzling accuracy. it became clear to those present that a stethoscope wasn't needed when he could observe and palpate and percuss. As far as I am aware, he never gave any hint of having been duped and so his reputation was further enhanced.

Dr Charles Baker was another charming old gentleman and though he wasn't much over sixty, it must be realised that to mere students of nineteen or twenty years old he showed signs of fossilisation by dint of a forty year difference in age. It was rumoured that he was rather shocked by the vogue for cardiopulmonary resuscitation that was all the rage at Guy's and he expressed that view that if ever he had a cardiac arrest it would be at the corner of a very large field before any of 'that lot' could get to him. He was a very wise man. He, too, was much loved by his students.

We were indeed fortunate to have Dr Willy Mann to teach us. He had been Physician to The Royal Household from 19564-1964, and then Physician to Her

Majesty, The Queen, from 1964-1970. Ultimately he was to become Senior Vice-President and Senior Censor of The Royal College of Physicians. In spite of such monumental distinction, he remained a wonderful teacher and if imitation is the sincerest form of flattery, then he was perhaps more imitated than most. He edited the 16th Edition of Coneybeare's Textbook of Medicine in 1974. Coincidentally, I have one of Sir John Coneybeare's ex-secretaries as a patient still. More importantly, though he had sat at the feet of the great physician, Sir Arthur Hurst, and his comments on cases of all kinds were peppered with medical anachronisms which brought the subject of medicine to life in a most entertaining way. It was said that you could hear a pin drop on one of Willy Mann's ward rounds and he certainly wasn't a man who stood for any nonsense. Woe betide the student who hadn't done a rectal examination on his/her patient. His views on the use and abuse of blood transfusion have stood the test of time. The bleeding duodenal ulcer and the gastric erosion were very much part of the physician's realm in 1969. It was Dr Mann's view that a man with a bleeding ulcer should be given a quarter of morphine and tucked away quietly in a corner of the ward where he would be undisturbed. Mist. Ferri Ammon. Cit sucked up a straw three times a day was the order of business. The houseman who set up a blood transfusion on such a case-and got found out- was asking for coals to be heaped upon his head, and Willy had a habit of turning up when he was least expected which wasto put it mildlyinteresting! Out in the Styx of General Practice his technique still holds good. My last case was a Roman Catholic and I called in the local priest who promptly gave the Last Ritesor The Sacrament of the Sick as it is now more euphemistically known. The patient made a very smart recovery having been worryingly sweaty and pale for a couple of days. Cimetidine and ranitidine have changed all that, of course, but those were certainly the days, and the management of the bleeding gut needed strong nerves. It was said that the successful physician should have no concept of timeand this was indeed so.

On one occasion there was a patient who had evaded any kind of medical diagnosis. Even so, Willy gave the ward round a sense of occasion when he announced:

'I shall prescribe this gentleman a tonic and I bet there's no one here who knows how to do that?'

There was a pause as the silence deepened.

'How d'you do that, sir?' I askedonce I'd got his bootlaces out of my mouth.

'Nux Vomica.' came the reply. 'Elixir Nux Vomica three times a day after food.'

It was a fitting conclusion to that patient's stay on Miriam Ward, Hunt's House, for he went home with the feeling that he'd had the finest treatment

from the best man in town and honour all round was satisfied. I never forgot that and from time to time I make a similar sort of announcement with regard to my intention to prescribe a tonic.

Dr George Scott was the Physician in charge of the Chest Department. He was always very busy and attended lots of meetings. It took me quite a while to discover that some of them took place at Lingfield. He had been Clinical Tutor in his time and his teaching ability combined with a capacity for friendly persuasion in the face of considerable mental density from some of the more numbskull members of the firm made him a popular choice for the students when they were opting for a firm. He had an uncanny knack of putting up an x-ray and then worrying at it from every possible angle until he had got as much information out of it as possible.

Tim Clark had become a Professor since my encounters with him on the Butterfield/MacLean Firm, and through him we learnt about the new technique of blood gas estimation although we still had to use Haldane's apparatus to get a result we weren't too sure of. It seemed a terribly fiddly way of going about things. It is worth taking some time out here to explain that the Haldane referred to was J S Haldane (1860-1936) and it was his son who was the great J B S Haldane (1892-1964). Physiologists may wish it the other way round butfor my moneyanyone who can write an essay as brilliant as 'On being the right size' gets my vote every time. I quote:

'An angel whose muscles developed no more power weight for weight than those of an eagle or a pigeon would require a breast projecting for about four feet to house the muscles engaged in working it's wings, while to economise in weight, it's legs would have to be reduced to mere stilts.'

(*Possible Worlds and Other Essays*, Chatto & Windus, London, 1927)

There was much excitement when Septrin/Bactrim, the sulphamethoxazole/trimethoprim combination first appeared. Professor Trounce waxed lyrical on the elegance of this new substance which seemed like a revolutionary approach to the knocking out of unsavoury germs that lived in the pulmonary tree.

Meanwhile, back in the Styx of General Practice we were in the process of changing from corks in the medicine bottles to screwtops. For years, we had found the humble cork to be just the ticket for containing healing substances in their glass containers but increasingly, with patients travelling by aeroplanes, there had been some rather messy revelations when they took their corked bottles of medicine up in an aeroplane. At their destination when they finally unpacked their suitcases it would be found that the cork had leapt forth from the neck of the bottle and their suiting had been anointed with Potassium Bromide, Gentian & Soda, Soda Bicarbonate, Potassium Iodide, Mist. Potas-

sium Citrate, Mist. Ferri Ammonium Citrate or whatever. Clearly the time had come for us to make a move and get right up to date which we did. In less than five years we were to find that we had stopped making these medicines for our patients because they were being superseded at great speed by apparently more effective medicaments that were coming onto the market.

The name of Guy's Hospital was often in the news, especially so in 1969 when the heart transplant was done on Mr Charles Hendricks. Mr Donald Ross had performed the operation, most ably assisted by the later, great Alan Yates, much missed by so many of my patients who had cause to be grateful to him. I remember coming into Guy's that Saturday morning and the hospital grapevine was fairly buzzing with the news as was the media. I felt terribly proud to be at Guy's, and in a rare fit of generosity, I vowed to become a blood donor. Having had a sample taken and been found to have a negative WR and Kahn I duly reported to the transfusion department to make my donation. As a procedure, it was quite painless, but I must have been somewhat teed up because the moment the needle was removed I promptly passed outwhilst lying down. I came to in what seemed like a second to find the form of kindly Dr Stoddart leaning over me and saying: 'Don't worry, Pitt-Payne. It's just a mental thing, all in the mind, you know.'

I felt a bit of a Charlie and it was a somewhat reflective pint of beer that made it's way to my stomach afterwards.

Recently, I had one of those rather surrealistic conversations with the wife of a man whose appetite was failing.

'I tried to get a banana into him yesterday, doctor.'

'I hope you remembered to peel it first?' I ventured.

Similarly, in the matter of drug-laden suppositories there are some rich pickings to be had. When prescribing a voltarol suppository and the like, it is always best to add the proviso that the medication will be that much more effective if the silver paper is removed first.

Sir Arthur Hurst came to Guy's from Oxford in 1901 and was appointed Assistant Physician to the hospital at the age of 27 in 1907. He suffered terribly with asthma and used the old-fashioned technique of one in a thousand adrenaline at a minim a minute by slow subcutaneous injection. His death came to him suddenly in 1944 whilst medicating himself. There were considerable risks in using adrenaline and the danger of sudden ventricular fibrillation was a problem. My grandfather, Pater, as we called him, was similarly afflicted and used the same regime for dealing with his asthma, a condition which had prevented him from attending the Great War. Whereas Hurst was slight and spare, Pater was built on sturdier lines being some six foot two and very broad. His penchant for self-medication also gave some cause for con-

cern, and one of my uncles told me once as to the nature of his technique. He always had a loaded syringe ready and this was kept in a small stainless steel box with a flush-fitting lid. This was carried with him at all times. When he found an attack was on it's way, it was but the work of a moment to give himself a whole millilitre of the stuff and it was done quickly without any reference to a watch. On one such occasion, he had taken this particular uncle to a burlesque show in town and the evening was getting a bit too much for him. Out came the little box, the old-style hypodermic needle was duly fitted to the syringe, and then he took his waistcoat, shirt and vest between his left forefinger and thumb. The needle was pushed sharply and firmly through all three layers of clothing and into the skin and the plunger was pushed home in under a minute. Then he dismantled the needle and syringe and put them back into the box and thence back into his pocket. He did it much as a seasoned practitioner might take snuff, and it always worked for him. He never bothered to boil his own needles up and used a new one when the old one became blunt or got snagged with his clothing. Not once did he infect himself and he survived the dangers of his technique. Guy Blackburn removed his gall bladder in the late forties when obstructive jaundice supervened. Post-operatively, he shook everyone to the teeth in Nuffield House when he was found to have a number of syringe loads of adrenaline at the ready in case he got short of breath. The memories of Hurst's demise were still very fresh, you see. Worse was to come the next time he was laid open for surgical inspection although this time they were ready for him in Nuffield House. Soon after the operation he felt rather ill and duly rang my father:

'Frank, I'm dying! Come and give me a quarter of morphine!' A paralytic ileus was diagnosed and as dripping and sucking had just come in, he was duly dripped and sucked. He was rather a dangerous old man but died in his sleep with his proverbial boots on in 1953. He was 78.

His attitude to women was nothing short of chauvinistic and his advice on the facts of life was very straightforward. When my Uncle John was off to sea for the first time, Pater summoned him to his study one day after breakfast. Uncle John found himself looking at a couple of Edwardian postcards with nude sepia-toned ladies on them.

'What are those?' he asked.

'Women, Pater.' he answered.

'Yes, women. Precisely! Have nothing to do with them!' he barked. End of lecture.

We saw a lot of lung cancer, increasingly so, and the effects of smoking were becoming more apparent due to the statistical efforts of the epidemiologists. In 1935, a case of adenocarcinoma of the bronchus was a rarity and worthy of

a grand round with Mr Russell Brock at the helm. Now the media are telling us that a third of us are going to die from smoking-related disease in the next twenty years. That's as may be, but if we are not to die of smoking related diseases then I would be interested to know just what it is we are going to die of. In 1935, TB was a common disease and many would die of it. Others would perish due to the ravages of syphilis, rheumatic heart disease, and kidney failure. The entity of 'malignant' hypertension was a spectre that haunted many. Penicillin ridded us of syphilis, cardiac surgeons worked their miracles on the heart and circulation, and dialysis eventually came to the fore. It became all too clear to me as a young student that whenever the doctors solved one problem they found several others associated with the fresh advances made. I see into the years ahead and we are about to become a nation of increasingly aged persons. In the next 50 years it'll be the care of the elderly that becomes a major business and with our successes in the field of contraception there will not be enough young people to care for those who have gone before. We have interfered with the natural order of things and we will pay the price. Is medical progress to become the victim of it's own success? Time alone will tell, but in due course it will be the lot of our profession to tell others how to die rather than how to hang on to the gift of life. When the day is nearly done, it is the GP who faces the last hurdle with the patient and I am left with that oft repeated aphorism of Pater's:

'A badly set fracture is a permanent monument to disgrace and a well-managed deathbed is a permanent monument to glory'.

He was an atheist.

The medical student would do well to think on these matters because it is they who will have to face the reality of medical progress as it comes to it's natural conclusion. Medical science can only go so far and then it has to stop, take stock, and say to itself: 'Where do we go from here?' Signs of what is about to happen over the next hundred years are already being heralded by the burgeoning numbers of quacks, charlatans, and pseudo-professionals masquerading under the guise of whatever alternative medicine cares to call itself. I shall continue to champion the cause of the allopathic doctor because I know no better.

I always liked that image of the doctor who was so clever that he had cures for which there were no known diseases. Maybe we'll come to that in due course.

J H Pitt-Payne

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Medicine

Practical Clinical Medicine by John Davies. Published by Butterworth Heinemann. Price £25.00.

This is an interesting book claiming to be aimed at both MRCP candidates and final year medical students. The text is clinically and practically orientated, as it's title suggests, and is not an in depth discussion of medical topics. It would not therefore, be sufficient for part 1, MRCP. Final year medical students wishing to prepare for the practicalities of life as a House Physician would find it informative, but it is system orientated rather than symptom orientated, and it is too large for an emergency text for the pocket.

Where I suspect it will find it's most appropriate readership is among those revising for part 2 of the MRCP, to cover those topics that may be discussed in the viva or in relation to short and long cases. There is useful discussion on basic physiology, and the tables and diagrams are well designed.

There are numerous typographic errors and relevant details are sadly sometime omitted; for example there is no mention of the relative merits of phase IV and phase V diastolic blood pressure readings.

At £25 this is a book to be shared with colleagues; if it is to remain useful a second edition should follow soon, preferably in paperback at lower cost and with the text corrected.

Dr I D Starke
Consultant Physician for the Elderly

OBITUARIES

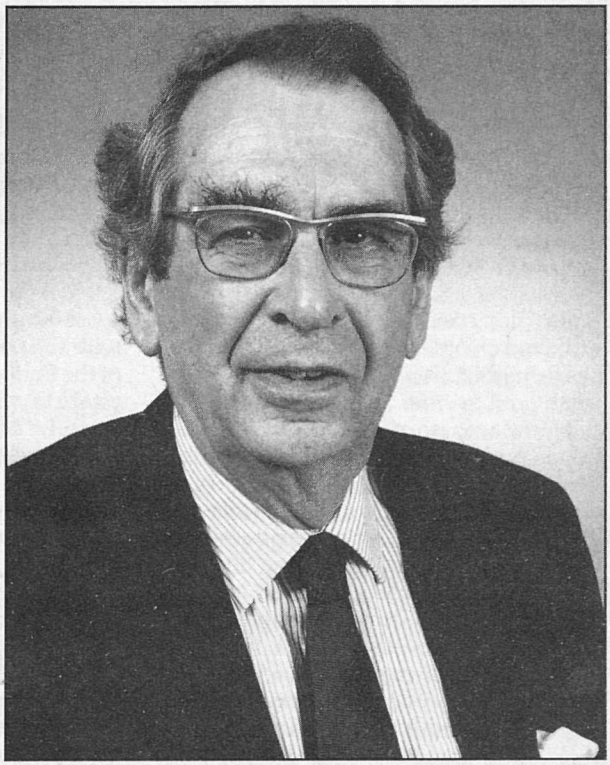
Mr A H Burfoot

His very many friends at Guy's will have been saddened to learn of the death from cancer on May 29 of Mr A H Burfoot. Harry first came to Guy's in 1946 as a Kings Fund Bursar to learn about hospital administration under Bertie Lees Read, the then Clerk. Following the creation of the NHS in 1948, he was appointed Assistant Clerk to the Governors and remained closely associated with the Hospital until his death. When Lees Read died in 1960, Harry became Clerk and I had the good fortune to join him as Assistant Clerk.

He very quickly taught me his and the Board's priorities, one of which was the total redevelopment of the Guy's site through a series of phases, using the surrounding bomb damage sites that the

Governors, with Lees Read's advice, had bought.

Teaching hospitals in those days had the advantage of dealing direct with the Ministry (later the Department) of Health, and the Governors, with Harry's advice, could successfully offer a grant from the Endowment Funds whenever it was thought that this might ease the starting of a project or provide facilities that would keep Guy's in the vane of medicine. This policy led to New Guy's House, and to the rebuilding of Boland House and Guy's House, followed by Guy's Tower. Successfully using money sounds easy enough, but, in the endless negotiations with the civil servants, Harry showed unshakeable determination and forward thinking that would have made him a success in industry, if he had not already become wedded to Guy's.



Harry Burfoot

I think of Guy's Tower as the 'saga of the chimneys' and here Harry showed his skills in looking ahead and in negotiating, from what at first seemed a weak position. The schedule of accommodation needed for the next phase inevitably meant building high because of our comparatively small site, but the Ministry said 'no, why not move the Hospital to the country?' Harry countered with the rail, bus and tube services that brought a constant large population to our doorstep and then played the chimneys card. He obtained professional proof that our 60 year old boilers were on the edge of their working life but that when replaced, would need very tall chimneys for the smoke to clear the surrounding office blocks that were about to be built. He backed this with wind tunnel tests, to make a case that the Ministry could not shake. The story is that they even suggested free standing chimneys—over 300 feet high—but that clearly was impractical and the only way of holding

them up was to build Guy's Tower around them. You can argue the case for or against Guy's Tower, but watching Harry working on the case against official opposition in order that Guy's should get what it felt was needed was like watching a virtuoso. Of course he surrounded himself with a strong team of professional advisors and planners and drove them hard to ensure that, when eventually the job was started, it would be done quickly and within cost. His success and his style attracted people to work with him and share his devotion to the good of the Hospital.

Harry was an exponent of hands-on management long before that term became a cliché. He also practised delegation but expected you to deliver the goods. At that time, to ensure the level of casework needed by a teaching hospital, the Bermondsey & Southwark Group of Hospitals was amalgamated with Guy's—'taken over' was the unofficial description. It matched the swing of the pendulum towards organisation on a large scale and Harry worked hard to make the amalgamation run smoothly both for the hospitals —as organisations and for the many individuals affected by it. He always found time for the individual, whether Consultant or cook, nurse or porter. People appreciated his concern for them and his obvious shrewdness in the business side of the hospital. He was a hard man in the sense that he always tried to bring people to his practical way of seeing things, but he always found time to help you if you needed it, or at least to show appreciation of your efforts if you didn't.

In the early 1970's when the first reorganisation of the NHS was being planned, Harry fought hard against the proposals for Area Health Authorities, which he thought would take management of the hospital out of local hands; but in the end politics prevailed and when the Board of Governors was disbanded in 1974 and succeeded by an Area Health Authority responsible for Guy's, St Thomas' and Kings, he resigned in the belief that a younger man would serve Guy's better in the new circumstances.

He had, however, been closely and successfully involved in the negotiations with the DHSS which lead to the transfer of the Endowment Funds of teaching hospitals to bodies of Special Trustees—instead of to the Area Health Authorities and he was appointed Clerk to the Special Trustees of Guy's Hospital. This was on a part-time, self-employed basis but it kept him closely involved with what was going on here and with his many old friends. He never accepted the new bureaucracy as he saw it and must have welcomed the move back towards local management with the creation first of a District Health Authority and more recently with the creation of Guy's & Lewisham Trust. He was also proud of the part he played on behalf of the Special Trustees in helping with capital developments—such as the refurbishment of Nuffield House, and in getting approval in principle for the start of the final phase of the redevelopment of Guy's. I think he would secretly have laughed at my use of the word 'final' because his hospital was always having to adapt to meet it's new needs.

My knowledge of Harry over the years has been in connection with Guy's but he was greatly respected by a whole generation of senior administrators, initially in London, for his broad vision of what was best for Guy's and similar hospitals, and

for his tenacity in fighting for his principles. His negotiations and manoeuvres in 1973 for the safeguarding of endowment funds, already referred to, was typical of this. He lived to see the Guy's Endowment Funds considerably increased by the Special Trustees as a result, and subsequently put to excellent use in the Hospital and in UMDS.

For 12 years before his death he Chaired the Friends of Guy's Hospital, bringing his own down-to-earth approach to that body, as to so many others he was able to help.

It was the same in his Sussex village where he lived for so long and where he was as much a leading light as he was at Guy's.

In his private life—how he found time for it I don't know—he was an opera enthusiast and would queue for hours to get tickets for Glyndebourne. Shortly after the landmark production of Porgy and Bess, he bumped into Willard White in a pub and was delighted when, through the good offices of Mr Maberley, Willard White was persuaded to later become a Vice President of the Friends of Guy's.

At work his desk was a local joke—organised chaos—though he could always find what he needed, nor would he throw away any piece of paper—'you never know when it might be useful'. So often this proved to be true in some future negotiations.

In Harry's death, Guy's has lost a devoted servant and those of all categories who worked with him have lost an excellent friend. Always courteous, of unimpeachable integrity and with an infectious laugh, he nevertheless had a hard enquiring mind that contributed so greatly to his successful life's work.

P H J Le Fleming

John Orchover Forrest

John Forrest who has died aged 74 was a dedicated advocate of preventative dentistry. After qualifying LDS and completing a Dental House Surgeon appointment at Guy's in 1941, he joined the RAF Dental Branch. At this time a dental hygienist training course on American lines was being developed by the RAF and John was particularly impressed by the value of these dental ancillaries in the prevention of dental diseases.

After demobilization he started a practice in a suburb of London but found little encouragement for preventative dentistry under NHS regulations. For this reason he developed a separate private practice in Upper Wimpole Street where patients were willing to pay for prevention.

A great reader of dental literature—he seemed to require little sleep at night—he kept himself up-to-date, and was a founder member of the British Society of Periodontology. Now anxious to teach, in 1959 he became a part-time demonstrator in the Department of Preventative Dentistry at Guy's. Soon a valued and stimulating member of staff, he helped to plan the School of Dental Hygiene which opened in the already overcrowded department in 1962. Luckily for the future of this unit, he was persuaded to transfer to Senior Hospital Dental Officer running the dental hygiene course. Under his wise teaching the School had achieved an excellent reputation when he handed over to Donald MacFarlane in 1969. Also during this period he gained an FDSRCS (Eng) by examination and won the Gibbs Scholarship to examine the dental health of Olympic athletes in Mexico City. He remained an Honourary Senior Demon-

strator in the department until 1971 when the pressure of his other activities became too great.

These activities included writing books on preventative dentistry, a guide to successful dental practice, a handbook for dental hygienists and many articles and letters in dental periodicals, which continued unabated after his retirement from practice. A member of many professional societies, he was at various times president of the British Society of Periodontology, the British Endodontic Society, the European Dental Society and the Metropolitan Branch of the British Dental Association. Recently his international reputation was recognized by an honorary membership of the American Dental Association, and at the time of his death by presidency of the International College of Dentists.

Possessed of great wit and humour, he will be greatly missed. Our sympathies are extended to his wife, Irene, and two sons.

RDE

Stately as a...

Trams and Matrons share two things in common: they both proceed in a stately manner, and most people think they are things of the past. However, one reader has sought my views on Matrons—I think I might prefer to write about trams! I have previously expressed my views on Matrons: but since then both Parliament and the RCN have voiced opinions on them, earlier this year.

Michael Lord (Conservative MP for Suffolk Central) has called for the resurrection of the title Matron and added 'exclude men and restore Matron'. He said 'I hope this remark should not be seen as sexist, but I believe the Matron should be female until the day that most of the profession is made up of men'. Well, maybe

he has a point—the situation in most other professions is certainly in the reverse. However, if the grading of title proposed by Salmon over two decades ago had been accepted, not only would we no longer hear of Matron, but Sister would be a dodo as well. It was the Salmon Report which introduced the notion of the 'Nursing Officer', and if it had been adhered to, Charge Nurses would have been the non-sexist title for the grade of Sister. To replace a job specifying religious overtones by one with a military one may not delight everyone, except certain upper class men, whose reservations have more to do with doting on 'nurse'—all of which has little to do with our profession.

Also, I remember when men were not eligible for membership of the RCN simply on grounds of gender.

Returning to the recent call for Matron to be restored, and showing how it has changed, the RCN was explicit. 'Frankly they said—No!', retorted Duncan Nichol (NHS Chief Executive) on the occasion of his questioning on the matter by a Select Committee.

All this was before the General Election, so maybe we shall hear more from Mr Lord, who was re-elected. He said in January: 'I would like to suggest, without being too pompous, perhaps the profession needs to think again—I think you have to go backwards for progress'.

Well this is a novel idea, but maybe he is right. A lot of old ideas are often dusted off when it is realized that they are not so wrong after all. But in these days of 'equal opportunities' it is hard to see this particular venture going far officially, even if in a practical situation Mr Lord may find his suggestions acceptable.

I have considerable memories of Matrons: like memories of most people, they vary according to the Matron in question.

The hospital where I trained, on the south coast, possessed a fine Matron, she was respected, and looked every inch—and there were many of these—the part.

But when I came to London and worked in a small hospital, 'Matrons's Round' was more of a ritual than a useful enterprise. I recall one patient laying his troubles before this lady, who listened and smiled benignly, but on leaving the ward she turned to me and said, 'thank goodness I haven't got to deal with his problems'.

When I first came to Guy's, the Matron who welcomed me on to the staff asked if I would mind standing on a chair to adjust her clock, until she was reminded there was a repairer on his way. I believe she also said on one occasion that male nurses were useful for the part they could play in lifting heavy patients. So the reader may guess my views on Matron are mixed.

Of course, when Matron existed she had more control over a wider range of staff than any Nursing Officer or Senior Nurse today. I doubt if nurses will again occupy this position of power, which has been relinquished to general management.

Despite all this the title of Matron is once again alive and well in this hospital, even if the title is more nominal than a return to the practice as featured by Matron in the past. So perhaps we have come full circle. But then, so to Manchester now, and possibly Croydon in the future, and you will see trams again. Both are smart!

Denis Cobell

Guy's Hospital Gazette

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Farewell to the Physiotherapy School

The final celebration to honour the history and achievements of the School of Physiotherapy 1913-1992 was held in the Roben's Suite on Saturday 11 July 1992. About 200 people gathered. There were ex-students, student teachers, teachers secretaries and friends who have supported the school over the many years. The Guy's students ranged from the 1923 set to the present 1992 graduates.

A full 5 hours were enjoyed together as well as laughing over the old 'set photographs' and activities in Shepherd's House over the ages.

The official proceedings were introduced by the present Principal John Low. Jean Jones gave a speech which reviewed the happy events and memories attached to the school in Guy's which was welcomed with nostalgia and hilarity.

Ronald Cooper presented the main speech and gave the Toast to the School which will remain forever in memoriam.

Diana Innocenti

Mr Cooper's Speech—

Some years ago, in a flippant mood, I observed that I seemed to carry with me a jinx on whatever organisation I joined. At the end of the war, I had been posted to a succession of regiments which were shortly afterwards merged or disbanded, and, when I was demobbed, the physiotherapy school at which I was trained was soon afterwards swallowed up. Then, the school at which I did my teacher-training was similarly engulfed within a years or two of my leaving. Never, in 1969 could I have anticipated that my next school would share this fate.

The Guy's School was then in it's 47th year and was staffed by teachers of experience and renown. Also, it was able to choose it's students from the cream of the applicants. As the Massage School, it had been founded in 1913 by Hester Angove, and it had as it's Supervisor, an orthopaedic surgeon, Mr Trethowan. Both of these names will be familiar to you as they have been remembered by the prizes awarded on qualification to the outstanding physiotherapists of their year. The training at that time lasted for a year only, but in the 1920's this was extended when remedial gymnastics were included in the syllabus, and, later, when the Electrical and X-ray schools were combined with it.

In the mid-1930's, the X-ray school separated off again, and the Massage, Medical Gymnastics and Electrical Schools the forerunners of the 1947 Physiotherapy School came under the control of Sibyl Evans, a Guy's nurse, who was known as Sister, and who was still responsible to Matron's Office. Miss Angove had given 22 years of service, and Sister Evans was to top this by a year by the time she retired in 1959. In 1947, the year I left the Royal Artillery to start my training, the old Chartered Society of Massage and Medical Gymnastics (CSMMG) had transformed itself into the Chartered Society of Physiotherapy (CSP), and the first course integrating massage, exercises and electrotherapy had been instituted, but it was not until Miss Evans retired that the administration of the School transferred from Matron's Office to the Board of Governors of

Guy's Hospital. As a physiotherapist who also held a midwifery certificate, Elizabeth Tanner was an appropriate person to manage this change, and it was to one of her Deputy Principals, Jean Watkins, that she handed over to in 1963. Jean had been responsible for teaching electrotherapy, and the other Deputy Principal, Madeleine Stephens, who was concerned with massage and exercise teaching, opted to concentrate on her teaching rather than administration, and so it was that I was promoted to the Deputy Principal post, eventually to succeed Miss Watkins when she retired in 1968.

Guy's School had always prided itself on turning out physiotherapists who were individual and 'different', that is, not all cast in the same mould, and we have produced many leaders of our profession in both the clinical and academic field abroad as well as at home. For example, we have enabled physiotherapists from all over the world to obtain the teaching qualification, we believe with an understanding of the Guy's ethos. With the CSP and the Physiotherapists board of the CPSM as examiner, assessor and inspector, I have visited almost all the schools in the UK and Eire, and most of the hospitals in which their students gain their clinical experience. It was a pleasure to find a remarkable uniformity in standards of practice though on occasions salutary to uncover a shortfall but, at the risk of being accused of complacency, it was also a comfort to be able to feel that, somehow, we did it better at Guy's!

In the last half-dozen years, the school has been inexorably moving towards it's demise, and Jean Jones and, latterly John Low have had to struggle to maintain moral and to uphold the traditions of which we are all a part. It is especially poignant that these were also the years which saw the brief flowering of what was an outstandingly good new course, devised by the school staff, which was based not merely on the Hospital, nor even on the District, but on the whole Region. I hope those running the course at Brighton Polytechnic, the newly styled University of Brighton, appreciate the ground work done by this school (and I would especially mention Jean Jones in this context) in opening up student clinical placement throughout the South Thames Region. In our course, a pre-clinical academic year was followed by two modular years in which subjects studied in the classroom were immediately followed by clinical experience in just those areas of practice.

How different from the organisation when I first came to Guy's. The course lasted 3 calendar years and 3 months rather than 3 academic years, and started either in October or April. A probationary exam was taken, covering all subjects, at six months, and training could be terminated forthwith. The survivors then joined their senior colleagues in treating patients in the Guy's wards for an hour every morning, from 9-10am, before returning to the School to resume lessons. All the teaching staff went with them to supervise and instruct, and I, for one, had to learn a great deal in a very short time in order to stay ahead of my students. An educationalist of today might be aghast at the arbitrary and haphazard nature of this experience-gathering, but, give or take it's sink-or-swim philosophy, it did make our students—and staff—develop an ability to think fast, and to respond in accordance with first principles, in the face of the unexpected. This resourcefulness, I would like to believe, has been the

Mr Cooper delivering the speech at the Physiotherapy School's Final Function

hallmark of the students qualifying from our School.

To work, and I believe, to study, in the Guy's School was a happy experience. It mixed a degree of informality with a sense of mutual respect, and it produced young women and, latterly, men who were professional but who were also congenial. They were people whose personality had been given freedom to develop within a disciplined framework, and who had been encouraged towards and open-minded and questioning approach to their work. Guy's physiotherapists had and while you continue to practise, will have a reputation which is literally world-renowned.

It would be quite wrong, however, to regard the School as consisting solely of students and teachers. Over the years, we have enjoyed the dedicated support of our secretarial staff in my day, Irene Homes, Dolores Brandebourg (Mrs Ealey), Jill Gray and Sumi Baskarahand of course our domestic staff, among whom Lilian and Mrs Ford come especially to mind. And we could not have functioned without the support of, for example, the Works department, the Portering Staff and the Counting House. when I first arrived, I was introduced to the Chef, the Locksmith, the Upholsterer

and the Carpenter, not the Walrus, however, and these contacts were invaluable. As Principal, I had to report twice-yearly to the Board of Governors and her I should like to make mention of Harry Burfoot who, sadly, died a few weeks ago and I had regular meetings with the Medical Superintendent and the Hospital Secretary, who gave advice and guidance which were greatly appreciated. We had an Education Committee on which these sat, together with representatives of the consultant medical staff and of the Medical School. Personally, I was greatly beholden to Ian Macdonald and Jack Joseph, and I know that my predecessors and successors were equally fortunate in the support they received from the professorial staff. If only our UMDS-backed proposal for a combined Guy's/Thomas's School had been accepted by London University... The consultant staff, especially from the old Physical Medicine Department and, subsequently, the Rheumatology Department were always a great help in educating and, latterly, examining our students, and there was a general readiness to help which was a great encouragement.

We must not forget, and it is so easy to overlook, the patients, who, with such trust and goodwill, put themselves literally in our hands. I hope they found the experience beneficial, certainly, our students benefitted from it, and it was touching to see the willingness with which patients allowed themselves to be taught on before groups, particularly in preparation for final year exams.

I cannot conclude without paying tribute to all the qualified clinical physiotherapists who have been so influential in the education and development of their younger brothers and sisters—our students. Jean Jenkins was the Guy's Superintendent Physiotherapist when I came to Guy's, and she proved to be a wonderful colleague and friend, particularly when I was finding my feet as Principal. I cannot speak highly enough of the contribution made to the School, in good times and in bad, since Jean's regrettably early death, by the present Superintendent, Diana Innocenti. She was unfailingly helpful to me, and I know Jean Jones and John Low are also very sensible of her support. At one time, virtually all student clinical experience was gained at Guy's and the Evelina Children's Hospital, as it then was. Then, when the Guy's Group of Hospitals was formed, students moved out to New Cross, where Pam Davis (Mrs Malony) was Superintendent, and to St Olave's where first, George Dunn and later, Grace Acott took students under their wing and took great pains to ensure their development. As Principal, by the way, I was also Group Superintendent, and for a while, when Guy's Health District was created, District Physiotherapist. This last change made Lewisham Hospital available to us and Irene Cook, followed by Pat Aste, became involved with our students. Finally, as I have said, physiotherapy departments all over the Region opened their doors to us, and we held regular seminars in the School to discuss problems and determine future plans.

How very regrettable it is that, in the wake of all these innovative and pioneering activities the School has been closed. In nearly 80 years of it's existence, the School has had seven Principals, of whom three accounted for more than three-quarters of the period. I hope that they, past and present would allow me to speak on their behalf, and to offer our

collective thanks to all those students who have struggled to learn; all those teachers who have struggled to instruct; all those clinical physiotherapists who, having thought, 'my God, what are they teaching them nowadays?', have got on with it; and everyone else, who, by collaborating, arguing, agreeing, has given us eight decades so satisfying, so stimulating, so enjoyable and yet, at the last, so sad.

I give you a toast to :—

Guy's Hospital School of Physiotherapy!

The Netball Club— this last year

The Club has grown enormously since we began in 1990 with two teams now entered in the University of London League. The year started off with a well-supported fresher's Tour to Brighton in October. Unfortunately it lacked a little in Freshers but we hope to redeem that next year! Marigold gloves did a roaring business that weekend. The kidnapped mascot, I think, shall remain nameless (do you want another bucket?).

The Christmas Dinner was held in the Guinea Butt this year. This was well attended and we hope to have an equally successful one next year.

The Tour was to Florida in March 1992. Unlike last year when we got thoroughly hammered by the Jamaican National Team, the Florida Islanders were of a similar standard and the games were very enjoyable and much less predictable!

The year ended with a triumph on May 16 when the United Hospital's Cup was won in fine style by Guy's and St Thomas' first VII. This took place at Honor Oak Park. The tournament, revived after a couple of years of dormancy, will hopefully be an annual event that is recognised in the Medical School Calendar.

Thank you to all who played this last year and I stress that the Club welcomes all standards of play. Look out for the fresher's stall in Fresher's Week in October, details of the dates will follow.

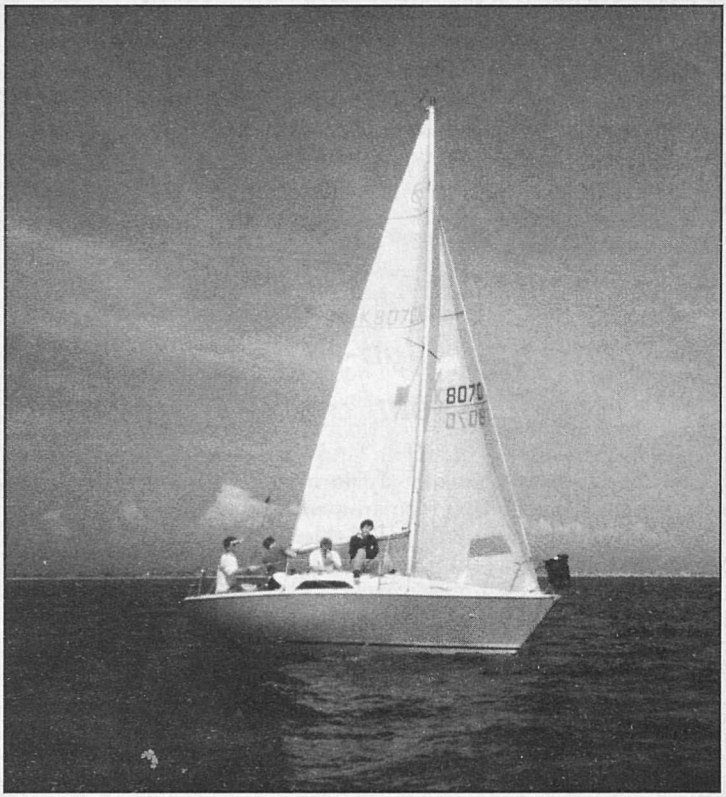
Aba Nana

Guy's and St Thomas' Sailing Club

Since no one in the sailing world had a clue what UMDS was, so emerged the new G&TSC, and what a start it has been for this new combined club! With sailing experience on both campuses, two new boats to add to our already enviable fleet, and newfound interest from both students and staff, the club looks set to go from strength to strength!

The summer got off to a great start with a weekend's racing at Itchenor Sailing Club, the home club of our Commodore Professor Sonksen. We took 24 students down, and pirated 8 Sonatas (the owners were allowed to stay on board to pick up a few handy pointers!), having 2 long races on the Saturday and match racing on the Sunday, in glorious weather.

This was supplemented by excellent sponsored dinners on both nights at Itchenor and Hayling Island Sailing Clubs, with copious booze, prizes, and the presentation of the Commodore's Cup to the winners. We frightened the Sonata owners at times, and frightened ourselves, but they invited us back to Cowes Week, so we couldn't have been all that bad!



A good weekend's sailing at Itchenor (**Photo:** James Read)

Contented smiles after the Staff v Students competition

The second event of the summer was the staff v students match at Seaview on the Isle of Wight. We hired ten Mermaids and commenced our assault on the staff who seemed unable to count how many crew their boats should have had! In the force four (plus) wind, and sheets of rain we gave them a good run for their money over five races, but unfortunately years of misspent time away from clinics obviously paid off for them, and the cup was reluctantly handed over at a superb dinner in the evening. Next year's date has already been fixed, and with a few (honest) changes of tactics we'll have the cup proudly back on our mantlepiece!

For those of you interested in sailing, be you staff or students, we are keen to recruit new members all the time and you can drop us a line via the Sailing Club pigeon hole!

Whilst you are there, take a look at the forthcoming events on the Sailing Club Notice board and sign up!

James Read
Captain G&TSC

Guy's & St Thomas' Hospitals Boat Club

Summer Report

Unknown to many, Guy's and St.Thomas' boat club has been in existence for 3 years. The aim behind the club has been not only to introduce men and ladies to the sport of rowing but also to put out high calibre crews which are capable of competing at national level and therefore to further the name of Guy's and St Thomas' Medical School.

This year we embarked on our summer training directly after the UH bumps—under the guidance of Chris Stone, our coach—we planned to row in both fours and eights events at the Henley Royal Regatta and then in fours at the National Championships.

Starting with a squad of twelve UMDS oarsmen we were faced initially with one minor problem—no boat! This was due to the fact that both the St Thomas' eights had been badly damaged during the bumps and that the officials of Guy's Boat Club (who had decided to row with Barts) were unable to lend us on of their eights, as they did not want to disturb the gathering dust. This problem was soon overcome after approaching University College who lent us an eight that can only be described as secondhand.

However, not to be put off by such piffling details we were soon out on the water trialling for seats in what was evidently going to be a very fast and experienced crew (with over 51 years of rowing experience between the 8 of us).

Reading Regatta

This was the first Regatta that we entered and when I arrived I was surprised to find that not only had the rest of the crew not arrived but also neither had our boat. By the Grace of God we arrived on the start of the first round, drawn against Tonbridge School and the Oratory School.

After 10 strokes I looked over at our opposition and was amazed to find that we were already ahead. After 1 minute I was somewhat shocked to discover we were still rating at well over 40 but our rating soon dropped as our less than perfect fitness (or fatness) started to tell. By this stage we had however extended our lead to over 3 or 4 lengths and went on to win easily. In the semi-final we were drawn against somewhat tougher opposition, in the shape of Radley College and Bristol Polytechnic, but again we thundered off the start, leaving a trail of foaming water behind us and also our two opponents. We eventually paid the price for such a fast start and were gradually rowed down. Radley College beat us by a narrow margin, but not to be downhearted we continued with a heavy training session in the enclosure bar much to the amusement of the assembled throng.

Henley Royal Regatta

After several more weeks of training Henley beckoned. Commitment was unbelievable with 2 of the crew rowing on the day of their written final Pathology paper and various others squeezing in outings either before or after exams. Even the Marshmallow Man shed some of his spare tyres but was still distinguished in

being the heaviest competitor at the Royal Regatta.

The qualifiers for the Regatta were, as always, on the Friday preceding the Regatta, and both the four and the eight had to qualify for the Visitors Challenge Cup and the Temple Island Challenge Cup, respectively.

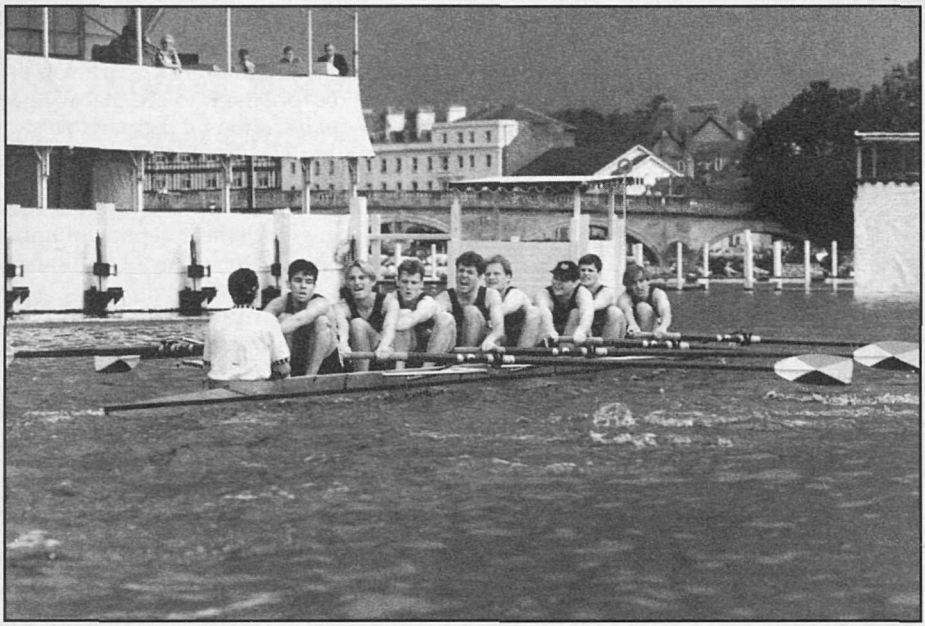
The four rowed first 8 and after a chunky and controlled row (in what must have been the oldest boat at the Regatta) qualified in the top 9 crews, and were rewarded with a place.

In the eight we rowed strongly but really needed a slightly higher rating to guarantee qualifying. However, at the finish we were all suitably tired and felt that we had rowed as well as we could.

When the results were posted we were all very disappointed to see that we had missed qualification by the narrowest of margins, but encouraged by the fact that we had not only thrashed all the other London hospitals, but also the other London colleges (with the exception of Imperial) and also beaten many of the Varsity colleges.

Afterwards, apparently there were several stories concerning bottles of wine, curry at the Smegma, and liaisons with Freckles, however I deny all knowledge but suffice to say I had a rather sore head the next day.

Guy's and St Thomas' Visitor's IV feel the pain in the finishing straight at the Henley Royal Regatta



Guy's and Thomas' First VIII racing for a place in the Temple Challenge Cup (No prizes for spotting the Marshmallow Man!)

During the Regatta the Guy's and St Thomas' coxless four were drawn against Imperial College, who were one of the seeded favourites, but the boys were not overawed and after a strong start found themselves half a length ahead at the Barrier (one-third distance), by Fawley (half the distance) G & T had extended their lead to three quarters of a length, and were still ahead as they entered the enclosure. Imperial College however, put in a big push to which G & T were unable to respond and Imperial College eventually won by half a length in the closest race of the day. This was a fantastic performance by a somewhat untried crew who succeeded in putting the frighteners on the strongly fancied Imperial College Crew.

Needless to say the rest of the regatta passed by in somewhat of a blur but many thanks to the officers of St Thomas' Boat Club, for putting on such an enjoyable cocktail party on Saturday evening and also to family Hayter for looking after us so admirably during the week.

Steven Pryke
Guy's and
St Thomas' Boat Club

Kingston Regatta

Kingston Regatta is a large event where all the races have reparcharges, so that every crew is guaranteed 3 or 4 races. G&T picked this opportunity to triple enter, with an eight, coxless four and two pairs. We faced a race program of 8 races with only a few minutes rest in between.

Senior II Pairs
In the first heat Weir/Gray (generalised lymphadenopathy) raced Pullan/Rodgers (cat killers) and Kingston. Cat killer took an early lead but had an unfortunate confrontation with a pleasure cruiser and retired. Generalised lymphadenopathy went on to win the heat, the semi-final and final, beating Molesely by 3 Lengths, picking up two tankards.

Senior III Eights
The VIII had a new cox on board who had never raced at a regatta before. This proved to be our undoing as 5 man's blade hit a navigation boy and ripped out of the gate, flew through the air and hit the stroke on the back of the head. Seven man's spleen was severely tested by a blade in the ribs. We paddled into the bank, dazed. After the-once-over by Dr Makings we limped back to the pontoon.

Open Coxless Four
We rowed in the open event in preparation for the National Championships. The semi-final was a row over. We lined up against Molesely and Wallingford in the last race of the day. 2 minutes into the race, with the crews still level, there was a big clash as we all tangled in the centre lane. The Umpire called us back to race again. After a rather tired row we lost to Molesely by 1 Length.

National Rowing Championships of Great Britain

Mens Heavyweight Coxless Four
This event is held every year in Nottingham on a spcialist 2000m rowing lake. To our knowledge no hospital crew has ever raced at this event before. The standard of crews this year was very high reflecting the best of British rowing. However, lurking in the reeds on a quiet stretch of the Thames were the G&T crew in their now infamous old wooden boat—'the log'.

In the first round we drew Leander (winners of Stewards Challenge cup at HRR), Nottingham County (lightweight World bronze medalists, winners Wyfold Cup HRR) and Sterling the Scottish Champions. Lady luck was on our side when Leander failed to show on the start and we automatically went through to the semi-final.

Our race plan was to go out hard and hang on. We were off the stake boat at 43 strokes per minute and strode to 39. At the 500m mark we were level with Notts County, but fell back by 1000m. We finished 5th, missing a place in the final, but were pleased to beat Cambridge University (who were a seeded crew at Henley) by 8 seconds.

Thanks must go to Chris Stone who coached us all season and the following clubs for lending us equipment : UCL, City Uni, Tideway Scullers, Imperial College, Kingston Grammar School and St. Thomas' Hospital Boat Club.

Thanks also to St Thomas' for financing the rowing along with the Clubs Union.

Guy's Hospital boat club itself played no part in the crew, wishing to row with Barts. It was a great shame that they would not lend their coxless four, which they did not use, leaving G&T with an out of date, overweight, uncompetitive boat. Hopefully, there will be more cooperation next year between the clubs.

David Pullan
Captain
Guy's and St.Thomas'
Boat Club

New Doctors

The following students qualified MB BS (London) in June 1992:

Agrawal, Miss R K
Ali, Miss R S
Allerton-Ross, G
Anand, S
Armitage, A R
Ayers, Miss S J
Bachelani, Miss Z
Bates, P G
Beadsmoore, Miss C J
Bhagrath, R
Biswas, Miss C
Black, E A
Boyce, Miss A C
Brett, T J
Byrne, P G
Cassidy, Miss S J
Causer, Miss C A
Chauhan, S K
Cheema, Miss B K
Chhaya, S A U /
Chukwuemeka, A
Clapton, Miss R E
Cooper, R C
Corner, A J
Coucher, J R
Cowley, E J
Crick, Miss A P
Crossman, J E
Currie, L J $
Davison, S C $
Devereux, Miss E J
Dhanjal, Miss M K
Downes, P G
Ekwuru, M O
Elkington, N M
Eyears, J M
Fade, Miss P Z +

Fearfield, Miss L
Fielding, Miss S P
Fisher, Miss A J
Fletcher, Miss S
Forsythe, Miss S L
Fouque, Miss C A
Francis, I S
Frewer, J D
Faunt, Miss K J
Giles, J W
Gohil, J =
Gomez, C K
Griffiths, H +=
Grove, M L
Hardee, P S G F
Hardingham, C R
Hasan, R
Hawkins, Miss S D
Haywood, R M
Hoskins, Miss E A
Hrouda, Miss D
Jacobson, T Z
Jain, Miss M
Jones, Miss R D
Kermani, Miss A H
Khwaja, S A I
Knights, Miss K V
Langley, C N
Lavender, C P
Liew, Miss F
McLeod, A D
Martin, R K
May, Miss S A
Mehta, A
Miller, Miss F N A C
Mok, A
Morris, H R /+
Nandi, Miss L R S N
Neil-Dwyer, J G $
Norgate, D A
Phillips, C E W
Pittman, J A
Plunkett, T A /$+*
Prinja, Miss A
Prosser, Miss R E
Pryse, J G
Purwar, S
Ragooswansi, R H
Rean, Miss Y M
Reddy, G
Roberts, C P
Rogers, Miss S M
Rushman, N R
Russell, R E K
Ryan, D J
Sandhu, Miss C
Sarker, P
Satchell, S C $=
Savage, Miss A C
Savine, R L E /+=
Scott, R J
Selmon, G P F
Sethi, A S
Sharma, A
Simon, Miss F L
Sims, P J
Singh, S
Smith, Miss D J
Smith, M J
Solan, M C
Sollis, Miss M E
Sood, M K
Srivatsa, Miss G *
Staffurth, J N
Steinlechner, C W
Stevens, Mrs A $
Sulkin, T V
Sundaram, K K
Taghizadeh, A K
Taussig, Miss C S
Taylor, Miss E J
Thickett, D R /
Thomas, Miss L J
Thomas, Miss S C
Tothill, Miss C L
Wakeling, Miss E L =
Wang, S T-S
Ward, Miss A V +=*

Werring, D J
Wharton, S P
Williams, G D
Wise, M E
Woodcock, Miss J F
Wright, D J
Yeomans, S J

The following students qualified MB BChir (Cantab) in June 1992:-

Aitken, C R R
Banerjee, Miss R M
Broughton, N I
Daukes, Miss H A
Fraser-Andrews, Miss E +$
Hanna, Miss S J
Hardwick, J C
Jourdan, I C
Kalra, P R
Lim, I J
O'Carroll, Miss A M
Otton, Miss S H
Price, A J
Santhouse, A M
Vance, Miss G H
Wagstaff, M H
West, N E
Williams, Miss R S
Wyatt, Miss M E +$

* Distinguished in Clinical Pharmacology
\+ Distinguished in Medicine
/ Distinguished in Obstetrics and Gynaecology
$ Distinguished in Surgery
= Distinguished in Pathology

Pathology Distinctions

The following students obtained Distinctions at the Final MB Part IV (Pathology) Examination in June 1992:-

Gallety, N
Hazel, Miss S P C
Taylor, Miss A

Birth

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The Park in 1914—on Graduation Day.

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Marie Fisher, Office Supervisor and Barry Smith, driver from south-east London depot of Interlink Express Parcels Ltd with a donation of £120 for Ronald McDonald House. It took only a few months to fill an empty one litre vodka bottle with 5p pieces in an office collection.

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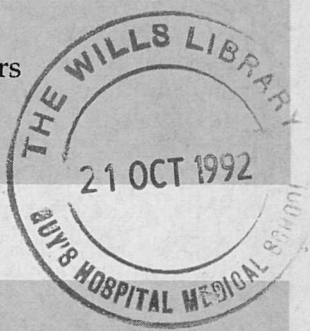

Guy's Gazette

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The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

If I may first of all respond in kind to Hilary Martin, who served the *Gazette* as a consistently excellent Deputy Editor, coping with all sorts of unexpected circumstances—like for example the time when the Passim I sent to the office in a mad rush before going on holiday spent three weeks circulating in the internal mail whilst poor Hilary was frantically waiting for it to arrive as deadlines came and went. That's right folks she had to write last month's Passim at very short notice, which explains why I'm still editing the *Gazette*. I think that at times like these it is appropriate to say that 'reports of my demise have been greatly exaggerated!'

It was a happy coincidence that this year's Freshers' Fair fell on the same date as the Biennial Dinner. Just as a new batch of students were being introduced to life at what are now the united schools, former generations of Guy's graduates who cultivate a profound interest in their *Alma Mater* met to renew old acquaintances and learn how Guy's has adapted since their time. A quality shared by all successful institutions, and even philosophies, is an inherent ability to adapt to and meet new challenges and situtations whilst at the same time losing nothing of their own unique character and essence.

Certainly for newcomers to Guy's and St Thomas's, challenges will be ever present. In all cases, a challenge is an opportunity in disguise. Some will be opportunities to excel in sport or academia while other trials may be an opportunity to discover more about one's own character and ideas. The Fresher's Fair, if nothing else, clearly demonstrated the tremendous variety of arenas in which one can participate, but the single most important thing to remember is that no club or society is anything but for its members, and the energy and enthusiasm that is invested is the only thing that will yield dividends.

Since I've mentioned dividends, let me just plug the *Gazette* Christmas raffle. Tickets have been issued to subscribers, and are otherwise available from the Gazette Office. Stapled stubs and remittance should be returned to the Gazette Office, Boland House, St Thomas' Street, London SE1 9RT. The draw will take place on 17 December.

Mr not Dr

Dear Sir,
I enjoyed the *Gazette* feature on the 'Heraldic Tradition—Part of our Heritage' by DC Watts.

However, I note the Dr Hooper mentioned, was Kenneth Hooper Dental Surgeon to Guy's Hospital 1931-58. When Mr JW Mansie unveiled the Dental Society Roll of Honour board reported in the *Gazette* in 1991, he made reference to Kenneth Hooper as 'the last of the gentleman dental surgeons'. It would therefore seem more appropriate to address him as Mr and not Dr Hooper.

Yours faithfully,

D R RADFORD
Department of Prosthetic Dentistry
UMDS

Heraldic tradition

Dear Sir,
I am surprised that the interesting article by D C Watts (*Gazette*, June 1992), has not prompted comments by readers on the errors in the Guy's coat of arms. I was delighted with his pungent criticism of the ornate shield, the awful helmet and the supporters' judo garb.

It is interesting, however, that there is no correct or standard shape for the shield—only the lozenge for the distaff side is customary. The College of Arms design, as shown in colour in Hujohn Ripman's *History of Guy's*, is a considerable improvement although the helmet they chose must have been the ugliest they could find—it looks like the conning tower of a submarine, or a dustbin and it's much too big—while the pointed wings of the supporters look like those of an African vulture. The more gently rounded tope in Mr Kenneth Hooper's charming drawing look more like the wings of a dove, I think.

I have one further comment on the three *fleur-de-lis* on the chevron, which are coloured in a metallic blue, with an encircling band. The origin of the *fleur-de-lis* is a subject of much controversy but most accept that it was at least, a flower. It was part of the achievement granted to the Du Lis brothers by Charles VII in 1429. It became part of the English coat of arms and was always depicted in gold on a blue field. The curious band around the flower appeared much later and was, I suggest, a misrepresentation by some artist of the original flower, which introduced the idea of it becoming the point of a lance with the band as the metal ring securing the head to the shaft, and it was painted blue.

I would prefer the *fleur-de-lis* in the Guy's coat of arms to be white, which would be acceptable on a gold background. With these modifications I would like to see the correct form of Guy's coat of arms as the front of the *Guy's Hospital Gazette*. I hope others will express their views.

I remember Mr Kenneth Hooper, a Guy's consultant dental surgeon who once presided at the Biennial Dinner. He was an accomplished genealogist and gave fascinating talks on the subject with excellent slides. He was always immaculately turned out with highly polished shoes and the last time I saw him was in Tunbridge Wells when he walked into the station on his way to London. He wore a black evening coat with velvet collar over his evening clothes, a silk scarf and an opera hat—the glass of fashion

and the mould of form. I doubt whether I shall ever see an opera hat worn again.

I also remember Mr St John Rumsey, who was a specialist and he too, was always smartly dressed—conspicuously so!

It was my good fortune and pleasure to have lunch a few days ago with Kenneth Hooper's son John and his wife Jill—both Guy's of course—and among the guests were two Guy's Sisters, 'Griff', alias Sister Griffin and Margaret Duncombe, both of whom I knew well—and the Guy's coat of arms was discussed, but when they saw the photograph of the fragment of Copeland crockery with the crest on it, they both said that the china in the Nurses' Home in their day all carried the crest while the colour of the china differed for nurses and for staff. They marvelled that there were not more fragments under Guy's!

Yours faithfully,

E D GRASBY
Fothersby West
Hawkhurst
Kent
TN18 5DB

Not the Guy's Boat Club

Dear Sir,

We refer to the articles by Messers Pryke and Pullan in the *Gazette* (September 1992) concerning the exploits of the Guy's and St Thomas's Hospitals Boat Club and to the rather cheap snipes at Guy's Hospital Boat Club which the articles contained.

The two gentlemen concerned left Guy's 15 months ago in a torrent of tears and a hail of expletives following the Club's decision at its AGM to torpedo both Mr Pyrke's generous offer of captaincy and St Thomas's equally generous offer of amalgamation, a decision which incidentally was unanimously affirmed by the Club at this year's AGM. This was no douby for fear of prejudicing the enduring success of Guy's being the only rowing club—within the wide range apparently now available at UMDS—to introduce and encourage as many newcomers to the sport as possible. Unlike the competition, we are not simply a vehicle to satisfy the egos of a very small number of established oarsmen.

Shortly after the gentlemen's departure, a dormant UMDS Boat Club was dredged up by an equally dormant St Thomas's and relaunched in the name of Guy's and St Thomas's as some form of secret weapon to sink Guy's. So secret in fact was it that it mercifully remained submerged for most of the year until resurfacing this Summer with a skeleton crew to take a few political pot shots at Guy's. Fortunately for us, it has not always been plain sailing for G & T with its freshers being lost overboard without trace sometime around Christmas and its last two hospital-trained oarsmen being ordered to walk the plank just before Henley.

To be serious for a moment, the Club was never actually asked to join a G & T crew or to lend an eight, and in any event G & Ts precious eight was repaired in good time for Henley. If Mr Pryke saw dust gathering through his periscope, it must have been on the pile of tired excuses which prevented St Thomas's and its alter ego from making a single men's

competitive entry between Christmas and the Bumps. Around 60 active members (with many more rowing socially) coupled with 52 entries in 20 events last season (leading to seven first and seven second places), meant that our eights were scarcely out of the water.

As for our coxless four so coveted by G & T, we can happily confirm that it was loaned throughout the whole season (including Henley and the National Championships) to Tideway Scullers as a very inadequate *quid pro quo* for their loan to us of two eights and a set of blades in order to bolster our fleet to meet the enormous demands made upon it this year. If this left poor old G & T with only (to quote Mr Pullan) an 'out of date, overweight, uncompetitive boat' we are truly sorry but at least Marshmallow Man felt at home.

Yours faithfully,

JONATHAN ROBIN
Captain (1992-93)
ALEX CASH
Captain (1991-92)
Guy's Hospital Boat Club
Boland House

Access for the disabled

Dear Sir,

I was very pleased to see Sandra Carnell's letter in the June issue discussing access for disabled patients, staff and visitors. In my later years at Guy's, when I was confined to a wheelchair, I became very conscious of the problems on the Guy's campus and was able to persuade the administration to take some action (sometimes after some fairly tough talking).

For example, during the planning of the Guy's Tower I kept asking for toilets to be included in the reception area. This was ignored but in later years I managed to persuade the administration to place this now well established facility because the Friends were willing to provide the funds. The cost of this work in a finished building with no plumbing in the area was a great deal more than if it had been in the original design.

A number of other similar special facilities have been placed in radiotherapy, accident and emergency, and physiotherapy departments through the help of the Friends.

As a result of the establishment of the Disablement Working Party, I hope that there will be adequate toilet and other facilities in Philip Harris House. I was pleased to have been approached by the Working Party for my comments on their deliberations. I make a plea that their recommendations are acted on.

With regard to access to the Colonnade, I can remember that when Guy's House contained wards, there was a ramp at the side of the steps where the wooden seat is now on the Park side. This ramp was lost in the underpinning and refurbishment after the war, an oversight which is regrettable.

When I visit Guy's for a meeting, I am conscious of the need for a few reserved parking places for disabled drivers with wheelchairs who wish to be independent. These have been promised to replace the four that I had fought for, but were lost once Phase III was started. I will continue to make noises about this need if the necessary facilities are overlooked with the pressure on parking within the campus.

I must say that if I inform security that I am coming they always find me a space, and I am sure other regular patients in wheelchairs who drive themselves would be looked after if they gave prior notice.

Finally there used to be a way of getting wheelchairs into the Chapel through a back entrance. Is this still so, or has this facility been lost since the building in that area? I do hope not.

May the working party have teeth.

Yours faithfully,

PROF W J TULLEY
Former Dean of Dental Services
Bunbury's
133 Westhall Road
Warlingham
Surrey CR6 9HJ

Panning for plastic

Dear Sir,

I have been enjoying Dr Pitt-Payne's reminiscences and his reference, in the July *Gazette*, to the 10p coin that disappeared pre-nuptially only to re-appear post-nuptially. This reminds me of an occasion when I was serving as a dental officer at a RAF station in the Canal Zone.

An army major, attached to the station, was to marry one of the nursing sisters and on waking on the morning after his pre-nuptial thrash (just over 24 hours before the great event) he realised that though he still had the palatal portion of his partial denture, the solitary tooth, a central incisor, was missing.

The nearest dental laboratory was 50 miles away and the officer in charge would not have looked kindly on a rush job of this sort, so we proceeded on the assumption that the tooth had been swallowed. The station medical officer (a Guy's Welshman, who died at a sadly early age) prescribed a hastening remedy while I prepared a model on which, hopefully, I would carry out the repair.

The patient was instructed to 'pan for plastic' (a sort of NH version of the traditional conservation room pastime of panning for gold) and with only hours to spare the central incisor re-appeared. It was duly fixed to the denture base with some very primitive acrylic filling material I had and the major was able to smile broadly in the wedding photograph.

It is said that the average Englishman is obsessed with having his bowels open every day and this event shows the social disgrace that may lurk around the corner for the constipated.

Yours faithfully,

STEPHEN JOHNS
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Westbourne
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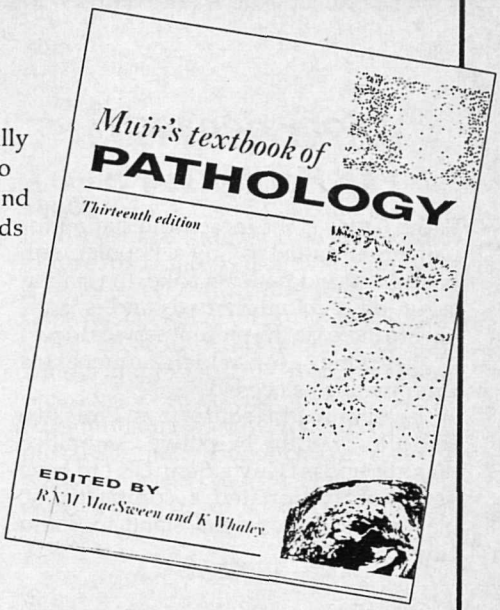

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Sony donation to Radio Guy's

Radio Guy's is the local radio station for patients admitted to Guy's. Popular with young and old patients alike, the station is run on a voluntary basis and is planning to increase the present service to two programmes, for which some extra equipment was needed.

In response to a request from Professor AHR Rowe of the Executive Committee of the Friends of Guy's, Sony UK Ltd have very kindly donated a compact disc player, microphone and stand to Radio Guy's.

Historical Essay Prize

The Lord Brock Memorial Trust, which is responsible for the old St Thomas's Operating Theatre and Museum, opposite Guy's Hospital, holds an annual competition for an historical essay on a medical subject. The prize is £200 and the winner is also granted three years honorary membership of the Faculty of the History and Philosophy of Medicine and Pharmacy, Worshipful Society of Apothecaries.

Prospective entrants should obtain approval for their proposed subjects from Professor Lord McColl, Director of Surgery (if based at Guy's) or Mr B T Jackson, Consultant Surgeon (if based at St Thomas's). Any medical historical subject can be chosen, but there should preferably be some connection with Guy's or St Thomas's Hospital or the medical school.

Essays should be typed and of not more than 5,000 words. Three copies should be submitted to the Clerk to the Special Trustees, Guy's Hospital, London SE1 9RT. Please print 'Essay Competition' on the back of the envelope, together with your name, in order that entries can be registered before being passed to the Trustees. Publication will be encouraged.

The competition is open to any one associated with either of the two hospitals. The closing date is the 28 February 1993. Good luck!

Pain research travel scholarships

UK based researchers on pain and its management who still hold junior posts are eligible to apply for one of 1,000 travel fellowships awarded by the Nurofen Pain Relief Project. To qualify, researchers must have had original research accepted for presentation, and provide an abstract and estimated travel costs. The closing date for entries is March 31 and the next judging panel will be presided over by Dr Patrick Wall. For further information please write to Nurofen Pain Relief Project, 4 Cloisters House, 8 Battersea Park Road, London SW8 4BG.

Hepatitis B immunization

A survey conducted by the Junior Doctors' Committee and Medical Students' Group Committee of the British Medical

Association has shown that 90% of the students questioned had been immunized against hepatitis B.

Research carried out previously by SmithKline Beecham, the vaccine manufacturer showed that only 40-50% of medical students were immunized against hepatitis B. The current survey follows an intensive campaign by the BMA to publicise the need for students and junior doctors to get vaccinated for hepatitis B before coming into contact with patients.

History of London health care

An opportunity to discover the history behind the famous institutions in London health care today presents itself in the form of a one day conference jointly hosted by Citisights of London and the Old Operating Theatre Museum. The conference takes place at 10am on Sunday 22 November at the School of Pharmacy, 29-39 Brunswick Square, London WC1N 1AX. Tickets are available at the reduced rate of £10 if you mention the *Guy's Hospital Gazette*.

Charity cycle ride

A Guy's dental surgeon, Robert Thornton, 68, (Guy's, 1946-51) is continuing his fund-raising efforts for the National Star Centre for Disabled Youth with another sponsored cycle ride this month. He has been raising money for the Star Centre since 1975, and has journeyed from Land's End to John O'Groats on several occasions, both on foot and by bike. In recognition he was awarded the BEM in the last Birthday Honours. We wish him well on this and other challenges he may embark on in future.

Class of '58

This unofficial Guy's 'club' has been meeting on a regular basis every year since 1963 for R & R (reminisence and recreation). Further enquiries should be addressed to Dr R W Elsdon-Dew, March House, The Avenue, Tadworth, Surrey, KT20 5AT.

From left to right: Robin Elsdon-Dew, Geoffrey Hayes, Ted Morgan, Jeremy Lee-Potter, Paul Sievers (qualified 1962) and Dick Hawley

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London to Paris by Bike

Original fund raising for Rag Week

Ruth Selwood, a first year medic, keen to do something adventurous for rag week decided to organize a sponsored cycle ride from London to Paris. She brought together a team of six other medics and a Guy's physiotherapist, Jo Stubbs, who had already successfully cycled coast to coast in America.

After a hectic Easter holiday organizing travel arrangements, we were all set to depart from Westminster Bridge at lunchtime on Friday 1 May. However, the first few hours of the trip turned out to be a complete shambles. The first thing that happened was a last minute rush to sort out some of our E111 forms which delayed us by almost an hour, then the last three members of the team managed to take the wrong turning off the first roundabout! Both groups decided it was best to keep going towards Dover and hope to meet up along the way. Unfortunately, Ruth who was in the trailing group lost control of her bike while going over a pot-hole and crashed onto the road fracturing her little finger. Nevertheless she dusted herself off and insisted on carrying on and even managed to catch up with the rest of the group at Canterbury. The last 50 km or so turned out to be the hardest part of the whole trip. The long uphill gradient in the rain really exacerbated our fatigue and injuries so it was a welcome relief to stop for some food 15 km outside Dover. Our morale was at rock bottom that night and we began to seriously doubt that we would make it to Paris. Nevertheless we pressed on to Dover Youth Hostel and tried to get some sleep in some unbearably humid rooms.

We woke up to a beautiful sunny Saturday morning which lifted our spirits considerably, and made arrangements to have Ruth's hand seen by a doctor. We decided it was best for six of us to catch the ferry as planned while Paul Nicholson and Ruth went to Dover casualty before continuing on the journey independently. So the main group went on ahead and caught the boat to Calais. As we were poring over our maps however, we realized we were aiming for the wrong youth hostel. So in desperation we decided to ring the casualty department from the boat and get in touch with Ruth who had booked the hostels. We managed to get through and Paul was called to the phone just as he was trying to find a puncture in his inner tube with a bedpan full of water! We sorted out the right directions and then had a relatively trouble free day

The intrepid cyclists—before they left! From left to right: Paul Nicholson, Paul Poynter-Smith, Ruth Selwood, Liz Martin, Declan O'Regan, Jim Shelley, Richard Crowson and Jo Stubbs. (**Photo:** Kate Prior)

of cycling in France in absolutely beautiful sunshine. Ruth, meanwhile, had her finger splinted and resolutely insisted on carrying on even though she was in considerable pain while crossing the channel as the anaesthetic wore off. Paul cycled with her the whole way and even gave her a hand up some of the steeper hills. They paused for refreshments along the way at the enticingly named *Auberge des cents biéres* where unfortunately Ruth received the rather amorous attentions of the proprietor. They were soon back on the road and managed to catch up with the rest of us at the youth hostel in Arras just before it closed.

After a sound night's sleep we all set off, reunited as a group, for the 150 km trip to Creil which was only 65 km from the centre of Paris. Again the weather was ideal, and we were averaging 25 kph along the flat. Things were going well until a bit of confusion and inexperience led to Liz veering off the edge of the road and losing her balance. She was grazed and shaken after her impromptu intimacy with the tarmac, but remarkably there was no stopping her, even though her front wheel was badly buckled! We continued through the very pleasant countryside with the wind on our backs and probably had the easiest cycling of all on that afternoon. However when we finally reached Creil we got a trifle lost around the back streets and seemed to get completely contradictory directions from every person we asked. After we finally reached the youth hostel we treated ourselves to some nice hot baths. Unfortunately these baths were so incredibly short that you had to adopt the lithotomy position to fit into the things. So feeling at least partially refreshed we splashed out on pizzas and ice-creams for supper. Paul N and Richard had both shaved half their beards off as an additional fund-raising effort which was to the complete bemusement of the natives. When Paul tried to explain the situation to the waitress in pidgin French all he received was a rather vacant smile and a nod. Someone suggested that if he had simply said, '*Nous sommes Anglais*' she would have understood perfectly!

The next morning we rose at dawn and made a quick start. It was a bitterly cold frosty morning but seeing the sunrise over the misty fields made it worth it. Although the journey was relatively short we had to keep good time in order to make our train and ferry connections. Unfortunately we lost Paul Poynter-Smith and Richard after we took a short cut which ironically led to them overtaking us by miles along the main road. Still, we kept going and finally reached the cobbled streets of Paris by mid-morning. We made very slow progress through the city but at 11am we caught sight of the pinnacle of the Eiffel Tower peering over the rooftops and soon afterwards we were standing in its shadow. It felt so good to have finally made it after four days of cycling, but we only had a couple of hours to relax and admire the Tower before having the obligatory photo-call and sadly having to cycle away to the Gare du Nord. It goes without saying that we missed our train but it did give us enough time to dismantle Liz and Ruth's bicycles so that they could take them as hand baggage and avoid paying the extortionate £18 fee for their carriage. We had a pleasant snooze on the train and caught the next ferry to Dover where we watched a beautiful sunset behind Dover Castle from a bracingly windy deck. We caught the train to Victoria, which brought us back for 11pm, and said our rather weary goodbyes before seeking the comfort of our beds.

Although at times it was tough going, we all still had a really enjoyable and rewarding time cycling to Paris, and for me at least it will be one of the best memories of the first year. In the end we notched up a total of 470 km on our bikes and expect to collect in excess of £1,000 in sponsorship money, every penny of which will go to the rag week charities.

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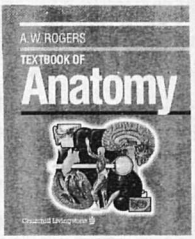

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Orpington Hospital and Rationalization

The end of an era

The sad death of Dr Neville Southwell reported in the *Gazette* of May 1992 and the process of rationalization in the Bromley District and its effects on Orpington Hospital prompts me to make some observations about Orpington Hospital and its association with Guy's Hospital over many years.

From 1 August 1992, acute medicine, like surgery before it, will leave Orpington Hospital which will then take on a different role. A neurological and rheumatological rehabilitation unit will be created. There will still be some orthopaedic surgery, geriatrics and outpatient services; but inpatient medicine and surgery will have gone.

Orpington Hospital formed very strong links with Guy's Hospital in the Second World War. Guy's consultants moved down to Orpington to perform surgical duties away from the Blitz. It should be recorded that subsequently many junior doctors took up house appointments, SHO and registrar appointments from Guy's Hospital as part of their training process. The wealth of clinical experience at that hospital was remarkable, and many of us are grateful for the experience and training that we received.

The consultant staff at the hospital was a very strong one, and until 1974, when reorganization of the NHS took place, Orpington Hospital was part of the Cray Valley and Sevenoaks Hospital Management Committee. Following 1974 it became part of the Bromley Area Health Authority. In the 1960s and 1970s most of the junior staff appointments were directly from Guy's Hospital and the popularity of those posts was due to the excellence of the consultants at that time, in medicine and surgery particularly, but also other specialities.

I went there as a medical registrar in 1967, having worked as a junior registrar at Guy's in medicine and in the cardiac unit, where I had worked for Dr Dennis Deuchar and Dr Charles Baker. I went to Orpington and worked with two Guy's trained physicians—Dr Neville Southwell and Dr John Williams. The clinical experience was remarkable and the training was wide. I had always been highly impressed by Neville Southwell from my student days when he would come to Guy's for the Friday afternoon clinical combined

meetings when physicians from the region would present cases. His attractive style, depth of knowledge and humour were very evident and working as his registrar was a great experience. I think that everyone who worked for Neville gained a lot, and I believe some of his style and skill rubbed off on generations of young doctors, whose professional lives will have been enhanced because of it.

It should be recorded that Orpington Hospital had the first intensive care unit outside London in the south east. This was created and supported by the enthusiasm of the consultant physicians, Drs Southwell and Williams, and by the enthusiasm of a series of registrars.

When I arrived, temporary transvenous pacing had not yet been undertaken, and I recall the first time we did this for a patient who was in heart block following coronary thrombosis. At that time the only temporary pacing boxes were mains driven. The patient was taken up to the X-ray department, the pacing wire was positioned transvenously under image intensification until satisfactorily placed and then pacing commenced. It was only then that we realised that we had the patient in the X-ray department about 3-400 yards from the intensive care unit and that there was no way of getting him back to the unit as there were no portable battery driven pacing boxes at that time! The solution came, however, when porters from over the hospital collected spools of cable which was then 'played out' down the corridor as the patient returned safely to the intensive care unit. The following day the hospital secretary sent a memo that this was a highly dangerous procedure to staff and visitors!

I also recall the first elective DC cardioversion that we undertook which was witnessed by Neville Southwell. I think he found the sight of it distasteful and flinched almost to the same degree as the patient's muscle spasms as the procedure was satisfactorily undertaken.

In those days the house physicians, when on call, were also casualty officers at night. This was a practice that was very demanding and was in due course corrected to reduce the burden. On Friday afternoons there were combined round meetings with the physicians from the Cray Valley and Sevenoaks Hospitals, and these were well attended by local general practitioners. It was an excellent form of clinical meeting when there was an element of cut and thrust between the various clinicians and the level of debate and discussion was a high one. Neville Southwell's Monday afternoon ward rounds were also well attended by local general practitioners where his teaching was in unique style, great courtesy and charm to the patients and a series of amusing anecdotes to those following, he was a wonderful raconteur; his rounds provided a high level of teaching as well as entertainment!

One of his great skills was that when science did not provide an answer to the diagnosis, he usually got the situation resolved satisfactorily by skilful management. His ability to treat patients successfully when there wasn't a clear answer was great. This is truly the art of medicine of which he was a great exponent. The training that we all had as junior doctors was remarkable, with a wealth of clinical material and experience and very sound teaching from Neville Southwell and John Williams.

I was delighted to return there as a consultant in 1972 and become a colleague of those two physicians. We had excellent surgical colleagues who provided a very high standard of care, but there was also a well founded fear that after Orpington was incorporated in the Bromley Hospitals changes would occur, and one of the major hospitals of the three providing acute services would be threatened.

'Rationalization' is now taking place. The acute services at Orpington have gone and the acute services are now to be centred on two sites—Bromley and Farnborough. This makes sense and will be more economical in the use of manpower. We look in the near future to building a new hospital on Bromley Common which will lead to the closure of Bromley and Farnborough Hospitals, though Orpington Hospital will still remain, albeit in a different form. The hospital has been instrumental in training a large number of Guy's doctors and those of us that were fortunate enough to work at the hospital in its heyday will never forget the spirit, experience and leadership that we were all lucky enough to have. The fabric of the hospital may not have been great, but a lot else was excellent and that created a good environment for many of us.

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Operation Tallin—a European Odyssey

Delivering ophthalmological equipment to eastern Europe

Sunday 5 July, day of departure for eight anxious medical students from UMDS; D-Day for Operation Tallin. Operation Tallin had eventually evolved from a challenge proposed by Mr Ffytche, consultant ophthalmologist at St Thomas's Hospital. It aimed to deliver ophthalmic aid in the form of equipment and literature to eastern European countries; Poland, Czechoslovakia, and ultimately the Baltic states—Lithuania, Latvia and Estonia. The capital of Estonia, Tallin, was the main destination, receiving most aid.

The team of clinical medical students Bella Agrawal, Naffis Anjarwalla, Sasha Lewis, Lucy Ambrose, James McNicholas, Sarah Lawman and Julian Speight initiated work on raising finances and organizing the route and transport with the help of other students and Mr Ffytche. By July, we had a total of £4,000 from numerous sources; £1,000 was provided by Mr Ffytche personally.

There were major obstacles which evolved during the preparations and it was with a nervous disposition that we finally left the serenity of London in our hired Ford Transit and Ford Sierra estate car.

Our route passed through Belgium and Germany, with our first night being spent in the comfortable home of an ophthalmologist at Erlangen. It was not until Tuesday 7 July that we celebrated our first delivery to Pilgen (home of Pils...which we tried later!) and to Prague in the evening.

From Prague, the two vehicles separated, delivering equipment to separated centres in Czechoslovakia and reuniting on 9 July in Bialystok. To Poland. The border crossings were quite an experience, with long queues of Fiat Polskis. However, letters from embassies enabled us to jump the lines. Both groups had similar experiences in that many places were surprisingly well-equipped yet lacked the basic materials such as gloves and gowns. On the other hand, certain centres were desperate for far more aid than we managed to bring; this was something which was distressing but could not easily have been predicted.

Members of the Tallin expedition: Bella Agrawal, Naffis Anjarwalla, Sasha Lewis, Lucy Ambrose, James McNicholas, Sarah Lawman and Julian Speight

The next day, yet another early morning start, involved the separation of the van and car; the car was to journey through the Baltics to Tallin. Problems had arisen because insurance had meant that only the car could complete the journey. Furthermore, the fully packed car only enabled three to sit inside! Risks of armed bandits stopping busses led to two students transferring to the van.

The two vehicles met four days later with a grand re-union in Warsaw. The car had successfully completed the trip, bandit-free, up to Tallin. They were amazed by the hospitality in all places, namely Kaunas, Riga and Vilnius. In Tallin, aid was gratefully accepted including a photocoagulator

Embassy letters facilitated some much needed queue jumping

and fundus camera. Although they had modern appliances, for example, Argon lasers, the cost of repair was too much when they broke down. Money was a great problem all over eastern Europe; an average car in Poland, a Fiat Polski was at least four year's salary for a doctor.

The van journeyed throughout Poland, amazed by its beauty. Centres visited included the old capital of Krakow to deliver a much needed vatrectomy machine; beautiful Gdansk; Lublin and Bydgoscz. All over the van and car managed to establish links for both doctors and students with London.

From sightseeing in postwar Warsaw, we moved forward in convoy to Poznan with our final boxes (including a Friechmann analyzer). Here we split into small groups and were given Polish hospitality in the homes of the local doctors.

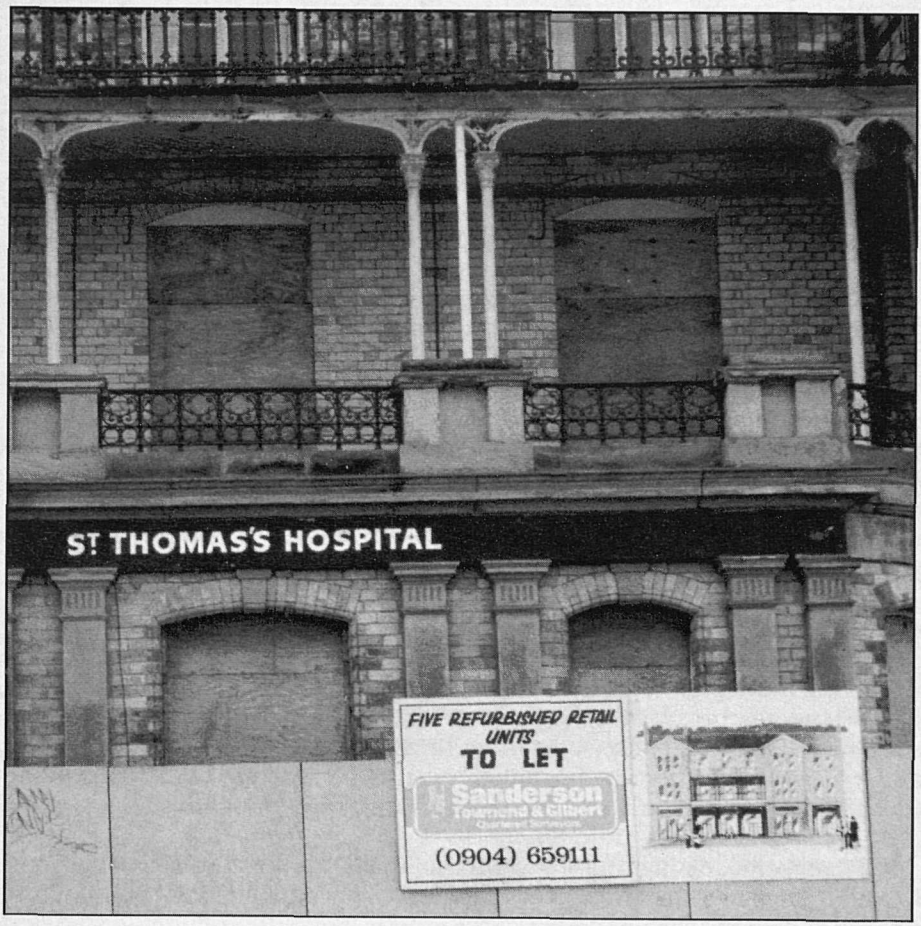
Thursday 16 July marked the date of our long drive back towards Ostend. We reached the port the next day, camping overnight and eagerly ready 4,000 miles later for our morning ferry back.

We completed a successful trip. Hopefully there is scope for future charity trips and also the opportunity to receive exchange students from eastern Europe.

Many thanks are due to Mr Ffytche, for his hard work over the last six months, and Pam, his secretary, without whom it would have been a hard struggle.

Bella Agrawal

Caption Competition



A £10 prize will be offered for the most original and funniest caption to be received. The closing date has been extended to 20 November to allow the Freshers to participate.
(**Photo**: Saikat Bannerjee)

In at the Deep End

Passing Finals—the start of real learning

The manner in which I became a rugby referee was something of an accident. What with little or no hand-eye co-ordination, I was an appalling practitioner of the game at Epsom; so bad in fact, that I spent my latter years at the school vegetating on what was then called 'fifth side'. I was in very good company. There was Alex Carlile (now QC, MP and Liberal spokesperson for something-or-other) and a chap called Peter Fuller who was killed a few years back in a road accident. Fuller finished up as Art critic for the *Sunday Telegraph*. He founded a magazine called *Modern Painter* and wrote 15 books. He too detested organised games and in his obituary in the *Daily Telegraph* (April 30, 1990) I can vouch for the schoolfriend who remembered him taking a pocket book about Modigliani on to the rugby pitch and studying it during the slack moments. There was also the bit where it said that he had been educated at Epsom College—which he loathed.

The games period was a time for meeting one's friends on the rugby pitch and indulging in a jolly good chat about this and that, a feature of the game which was as far removed from the spirit of William Webb Ellis as it was possible to be. If the ball happened to be caught, the thing to do was to get rid of it as quickly as possible before the body corporate was thrown to the ground and trampled upon by the ensuing mêlée. Tackling was something of a moot point on fifth side and a good tackle was almost unheard of and if one achieved it repeatedly one was in danger of being promoted to fourth side, which would have been a pity because they took the game more seriously at that level. When the First XV played at Home, the school was expected to turn out and watch, and it was as a watcher that I excelled because it really was a very good game to watch for me personally. As a player though, any moral fibre I may have had took a terminal dive into the mud.

The habit of watching rugby persisted at Guy's and on a Saturday afternoon I would drive to wherever it was my friends were playing and stand alone shouting the odd word of encouragement if it looked as though Guy's were moving forward. On one occasion, during the Lent Term of 1966, I turned up and it transpired that Guy's were a player short. There was a spare player who was to double as referee and he was asked to wear a Guy's jersey and I was asked to referee. I protested my ignorance but the pleading looks of one's

fellows won the day and so I began my short career as a rugby referee. During the rugby seasons that followed I refereed most Saturdays and quite a few Wednesdays, and the high point of my career was to referee the Staff versus Students Match on Boxing Day 1969. It was 20 minutes each way and though the outcome of that match has gone from my memory, it was a question from no less a personage than Dr Hugh Burry himself, an ex-All Black, that made my day.

'Have you ever thought of joining the London Society?' he asked me. It was like music to my ears but as I was about to qualify it would have been out of the question. Now, when I am asked if I ever played rugby, I say: 'I was once asked if I'd ever thought of joining the London Society.' In the matter of golf, I say: 'I gave it up when I was 18'. Regarding boxing, I say: 'I was runner up in the first round of the welter weight boxing championships—at my Prep School'.

When asked about exercise, I am somewhat guarded. One can fall off a bicycle and one can trip and fall when out running—or jogging as it is called these days. One can be mugged when out for a walk, or one may crash one's car when driving to the gym. On the whole, therefore, I tend to advocate lying on the bed or sitting in a chair as the safer alternative to exercise.

Christmas, 1969, was a great time and I can remember forming fours, as it were, behind a long crocodile of nurses with some of my more inebriated colleagues as we sang our way round the wards singing our version of many of the carols that were sung that night. It was Christmas Eve and the nurses turned their capes inside out so that the red substituted for black. Everyone had a good time and no one minded our reasonably childish antics.

My time on the neurology firm under the late Dr ICK MacKenzie was interrupted on 8 January 1970 when I qualified Conjoint. the Conjoint Surgery Examination written paper was held on 31 December 1969 from 2pm to 5pm. This included surgical anatomy and therapeutics. Question one concerned the anatomical relations of the duodenum and the pathological conditions affecting it. I could still answer that one now.

Question two asked for the anatomical relations of the left kidney and the indications for nephrectomy. As we had a choice between answering the first two questions, I opted for the first. The other four questions were compulsory. Question three asked for a discussion on the causes of chronic diarrhoea and the appropriate investigation appertaining thereto.

This question puts me in mind of the quite magnificent toilet facilities at Queens Square and the amazing way they were always so fully utilised just before an examination. What we students were doing in there may only be hinted at, but it was the nearest I came to a blue funk, and there aren't a lot of

them about these days. Question four asked for an account of the diagnosis, investigation and treatment of intracranial space occupying lesions which may result from a head injury. It put me in mind of the apocryphal story about President Idi Amin, who, it was suggested, had been shot through the head; the bullet passing straight through and missing his brain by six inches. Question five asked about the complications that may results from a bullet wound to the upper part of the thigh and the treatment of such a wound. the Conjoint Board had never asked a question like that before and one felt the strong wind of change blowing through the examination system. The last question requested short notes on papilloedema, fat embolism, stridor and tenosynovitis. In the days that followed we attended the Clinicals and Vivas. At 12 noon on 8 January 1970, we all queued up in the order of our exam number in the capacious hallway of the Royal College of Surgeons. At the foot of the stairs was a uniformed gentleman with a clip board and the proceedings that followed were brooded over by the marble presence of the great John Hunter who must have sat in that semi-circular recess for many a year now. We were instructed to proceed upstairs if we had passed. Those who failed had the option of leaving the building or going downstairs to the cloakroom. We shuffled forwards and then it was my turn. 'Four eight three?' I nodded. 'Mr Pitt-Payne, sir?' I nodded again. I stood there momentarily paralysed by the sudden surge of adrenaline that shot through me.

'You've passed, sir.' The man smiled at me. So I became a doctor and took the stairs upwards two at a time.

Upstairs, we lined up in a room, and when all those who had passed were there a line of venerable elderly gentlemen filed into the room and stood before us. They were dressed in smart black gowns with red facings and for a moment we could have been in 15th century Padua. Something was read out to us and then we left the room after they did. I rang home to tell them that there was another Dr Pitt-Payne on the loose and then went back to Guy's.

For the first time ever, I felt there was nothing further to be done there that day so I went home. We cracked a bottle of champagne and rejoiced *en famille* not only at my success but for my father's 57th birthday which just happened to be the same day. It was the best present I ever gave him, I know, though it was never in his nature to comment on such things. As a precaution, he had booked seats at the Fairfield Halls, Croydon, where we would see and hear Edmundo Raze and his band. In the event of failure, he had reasoned, the noise would blot out my sorrows and in the event of success the sheer exuberance of that band would highlight what had turned out to be a remarkable day. It was an inspired gesture because there was an anti-climax (as I suspect there

must be for the newly qualified doctor) and the racket that outfit made still rings in my ears today.

Armed with my brand-new Conjoint Diploma, I felt all dolled up and with nowhere to go. And then the phone began to ring. How the insurance companies found out I'd passed I was not to know, but no doubt the results had been published somewhere, and in the world of insurance there is nothing so fresh as the newly qualified doctor especially when it comes to selling them insurance. They'd ring up—these men—and call me by my new title, be very nice, and then do a hard sell down the line with all manner of smooth patter and business about the future—and all this before I'd earnt a bean. The take-home pay for a brand new houseman in those days was £14 per week. Not a lot, you may say, but it meant a lot to me; and it was somewhat galling to be in a position to earn something and yet not have a job. I have to admit that I gave them short shrift.

The neurology firm was interesting. My father had told me of two brothers called McArdle and when he had been a student in the '30s they were known as 'Red' Ardle and 'Black' Ardle due to their hair colouring at the time. In fact due to an oversight on my part—or possibly theirs—I do not believe I ever heard either of them speak though they were very much in evidence at Guy's in the 60s. When Michael Simpson wrote the Residents' Play in 1971 he called it 'Waiting for McArdle' (also, 'Oh! What a Lovely Ward!'). Only in retrospect was I to understand the joke implied in the title. In 1969, whilst still Chairman of the SMEC, the one thing our committee had achieved was the fixture of some noticeboards in the East Wing whereby those consultants who were late due to the ever-increasing traffic and commitments elsewhere, could advise us of their situation whereupon we would then all retire to the 'Spit' for further aliquots from the coffee reservoir there. This saved hours of hanging about on the ground floor of Hunt's House—or wherever—awaiting the arrival of certain said consultants.

One consultant—an emeritus physician no less—was Sir Charles Symonds KBE, CB, DM, FRCP. I attended what must have been his last ward round ever at Guy's. He was a very tall and distinguished man for his 80 summers and though advanced in years he carried all before him in an intellectual tidal wave the like of which I shall never forget. His capacity to speak on truly obscure neurological topics was a marvel and he gave a masterly discourse on the nature and presentation of hypokalaemic periodic paralysis. My father was his HP in 1937 and was inspired to take up neurology as a career but the war put a stop to all that. Sir Charles Symonds put me in mind of the biblical story of Ezekiel and the Dry Bones and if ever there was a man for making a dull subject interesting, it was him.

By the end of January, 1970, I was getting decidedly itchy feet. The constant commuting back and forth to the metrolops (sic) was beginning to get me down and I was afflicted by something of an ill humour. Though qualified, I was still a student. Nothing made a lot of sense to me and I knew not what I wanted or what to do next. My father had a brainwave; why not go to Jimmy Goodliffe at the Careers Office and go off and do a locum somewhere? It must have coincided with the arrival of my provisional registration documents for which I had paid the princely sum of 10 guineas. I rang Mr Goodliffe and he saw me more or less immediately and I found myself in the presence of a most remarkably kind man who seemed to know my mind even before I spoke. Within 48 hours I was on my way to The Isle of Thanet for my very first locum at Ramsgate District Hospital.

I was booked for two weeks and Fritz Baker would follow me and take the second two weeks. My first boss was to be Dr David Lillicrap FRCP and those two weeks gave me the experience of a lifetime. Within hours of getting there, I was being phoned by the casualty officer who was a local GP. Would I admit a man with tetanus? He'd cut his finger some 14 days previously but had not come back to have his stitches removed. If ever a young lad was thrown in at the deep end, it was yours truly, and, as I made my way to casualty my mind was wondering what to do next. He was admitted, of course, and the Indian Ward Sister took one look at him and concurred with the casualty officer. She'd seen at least 2,000 cases of tetanus in India. However, once tucked up in bed on the ward, his plight was rather less obvious, and, as he was somewhat less than monosyllabic in speech, it was hard to tell whether it was a risus sardonicus which leered at me over the counterpane. It was also a Friday afternoon and Dr Lillicrap was away for the weekend. The other consultant took a look at him and decided that the trismus was due to bad teeth and suggested that I make provision for a consultant dental surgeon to see him on Monday morning. I spent a fraught weekend trying to keep him heavily sedated because he became terribly jumpy and tended to twitch whenever anyone went near him.

Nevertheless, being the good houseboy I tried to be, I kept him quiet and referred to the ward sister at odd moments of doubt whenever I needed reassurance. When the dentist and the consultant in question visited him on Monday morning, he went into a full opisthotonus the like of which I have never—thankfully—since seen, and he was in the Brook Hospital that afternoon on a life support system. He did not recover, but my learning curve rose steeply from there on. We never counted the hours in those days, of course. They were long but it was accepted as par for the course and I am still one of those doctors who find themselves bristling inwardly at the political antics of

the junior hospital doctor. They are quite right, of course, in that we are probably wrong in our thinking that because we did it that way then so should they. I didn't expect a lot of sleep—nor did I get it. On my nights off, I found myself awaking in a cold sweat because I'd dreamt I'd prescribed the wrong drug—and the patient had died. On such occasions, I'd get dressed and pop down to the wards to check that everyone was still alive. I tended to dream of specific cases I'd seen that day.

At barely 22 years old I found myself called upon to take the kind of life or death decision such as when to give up on resuscitation, or when to turn the life support system off. In the dark hours, when there was no one else about there wasn't time to think too hard about the morality of what I did during those two weeks—but I got by and I shall always be very grateful to Dr Lillicrap for presiding over my 'trial by fire'. Valentine's Day that year was on a Saturday so a party was held on Friday 13. I was all done but for packing my bags and introducing Fritz Baker to all and sundry and showing him such ropes as I had familiarised myself with. It was a jolly good party, and, if I had distinguished myself in any way at all, I blew it all when I got off with one of the kitchen maids. It would be nice to say she was another notch on my gold-handled cane but I suspect I was just another scalp for her to hang on her metaphorical belt. Like everyone else at Ramsgate, her knowledge was greater than mine and I was very grateful to her when we parted company early the next day. I drove back to London with a silly smile on my face.

J H Pitt-Payne

The New Memorial Park

The history and development of the Park

Old maps show that, when Guy's House was built in 1725, the street to the south was a public thoroughfare—Collingwood Street. Gravel Walk led south from Collingwood Street through gardens and orchards beyond. You will soon see these old street names back on the walls of Guy's House and Hunt's House.

Guy's slowly acquired this land in the late 18th and early 19th centuries, and various buildings (now demolished) were erected around the Park area. They included the old Lunatick (sic) House which was later converted to accommodate the intensive care wards (on the site of the present Shepherd's House). Hunt's House was erected in 1857 when Gravel Walk was re-aligned along its western boundary. The Park has existed roughly in its present shape for nearly 200 years.

At the end of the First World War a Memorial Arch honouring the Guy's men and women who died, was erected at the entrance to the Park, on the junction of Collingwood Street and Great Maze Pond. This Arch had to be removed in the 1960s because it was not large enough to accommodate traffic. In 1994 the Arch will be re-erected at the main entrance of the hospital to be formed as part of the Phase III Development.

The plane trees were planted in the 19th century. The Park was re-landscaped at the end of the Second World War to commemorate those who died in that conflict.

Guy's is very proud of the Park, which is unique among London teaching hospitals. Like all such amenities, however, it had suffered from wear and tear and from the increasing effect of the plane trees. The generosity of the Special Trustees of Guy's has allowed us to re-landscape the park this year. The improvements include:

- re-laying pathways in York stone (using the original stone where possible) to match present travel lines and prevent 'pathways' being worn across the green lawns;
- providing more hard standing areas for benches;
- removing (sadly) some trees which were in poor condition and replacing them with 13 new species of trees. Although presently small these will soon grow to beauty. Originally the condition of the plane trees them-

selves was questioned, but happily, these have been given a clean bill of health.

- re-planting the whole area with fragrant shrubs which, when mature will give year round colour (predominantly the blues and golds of Guy's!)
- provision of a screened off bicycle park by Nuffield House
- re-surfacing the roadway and forming zebra crossings and speed ramps across Collingwood Street.

The Re-dedication Service

On 22 July 1992 a service was held to re-dedicate the Park. The service was conducted by the Reverend Neville Smith (the Guy's Chaplain) supported by Reverend Margaret Juhasz (representing the Free Churches) and Father Bernard McNally (the Roman Catholic Chaplain).

Dr Kenneth Maclean, representing Guy's men who had served in the Second World War, read a short lesson—Micah IV 1-5: 'They shall turn their swords into ploughshares'.

There was a good turnout of staff, patients, Guy's men and women and friends from the local community. Fortunately the weather, which had been wet and windy the previous week, turned out in our favour and guests were able to enjoy tea and strawberry tarts in the Park and the Colonnade.

Professor Declan Anderson, formerly Professor of Physiology in relation to Dentistry, nobly gave of his time and artistry to design, incise and gild the beautiful memorial plaque on Welsh blue slate. The plaque was unveiled by Mr Peter Winfield of the Trustees.

Professor Declan Anderson with Mr Peter Winfield if front of the memorial plaque

Special thanks must go to the following for their contribution: the Special Trustees of Guy's Hospital—particularly Mr Peter Winfield and Professor Cyril Chantler for their personal support and involvement; Mr Alan Tate of Healey & Baker—who gave generously of his time to create the landscape design; Professor Declan Anderson—for the design of the memorial plaque; the Guy's Design Team—specifically Derek Warden, the project leader and Mr Derek Morris of Heber Horticultural Services.

The inevitable postscript

Murphy and his Law always come into play at times like this.

Firstly, it was sad that many friends of Guy's did not know about the service, which was heavily advertised around the Hospital and local community. The notice to be printed in the *Gazette* prior to the event was unfortunately omitted. The Editor joins me in offering our humble apologies for this mishap. If there are any Guy's men who would like a photograph of the event, please let me know.

Secondly, a drain by the Medical School collapsed just after completion of this work. The drain was an original Georgian brick-built culvert—and so all the new plants had to be dug up while it was replaced!

Sandra Carnell
Projects Director

The *Gazette* is truly sorry that readers who might have liked to have attended the re-dedication service were not informed of the event in these pages—Ed.

New books from Blackwell Scientific Publications:

Clinical Anatomy

Eighth Edition

Harold Ellis

Be it for the palpation of the body cavity, the interpretation of a CT cross section, the location of an organ to biopsy, or listening to lung sounds, an understanding of anatomy in its clinical context is essential. This is exactly what Professor Ellis provides in this highly successful revision text.

- *structured by region - surface markings are followed by detailed discussion of each organ or component part*
- *anatomical descriptions are immediately followed by clinical features, making this book unique and indispensable*
- *300 illustrations, all in full colour*

October 1992, 512 pages, 300 colour illustrations, paperback, £22.50 ISBN 0632024097

Clinical Examination: A Systematic Guide to Physical Diagnosis

Second Edition

Nicholas J Talley and Simon O'Connor

In the new second edition of this textbook, the authors continue to provide expert guidance on how to obtain a history and perform a physical examination, the foundations upon which efficient diagnosis rests. The text commences with a detailed introductory chapter on the general principles of clinical examination and then presents specific details of history taking system by system.

- *a complete revision and update including a wealth of new tables and diagrams*
- *includes common and important surgical symptoms*
- *expert guidance on obtaining a history and performing a physical examination*
- *thoroughly illustrated with diagrams and colour photographs*

September 1992, 464 pages, 200 illustrations, paperback, £14.95 ISBN 0632034351

The Royal Marsden Hospital Manual of Clinical Nursing Procedures

Third Edition

Edited by A Phylip Pritchard and Jane Mallett

This new edition has been extensively revised and updated throughout.

- *all procedures are accompanied by rationale*
- *valuable to nurses at all stages in their careers*
- *versatile - can be used with many nursing models*
- *procedures are arranged in alphabetical order for quick reference*
- *clear illustrations enhance the text*

Each procedure is supported by a literature review of the latest research findings. Detailed guidelines give a step-by-step account of the procedure and the rationale for each of the nursing actions. Nursing care plans are included to demonstrate potential problems, causes and solutions.

An invaluable source of reference for nurses in any setting.

August 1992, 560 pages, illustrated paperback, £14.99 ISBN 0632033878

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Everyman's BNF

Medicines—a guide for everybody. 7th edition. Peter Parish. Published by Penguin Books. Price £7.99

The recent appearance of self-help groups and the increasing involvement of the laity in medical decision-making has made it appropriate that textbooks be written for use by both professional and non-professional people. Professor Parish's book on drugs in current use is for such a mixed readership. He writes in his introduction that he would like to see an increase in self-treatment and that with the aid of his book (and discussions with a pharmacist) the patient will be able to make better choices of 'over-the-counter' drugs and be able to participate with his or her doctor in deciding the most appropriate treatment.

Roughly one half of the book deals with general principles of pharmacology and describes therapeutic uses of drugs mainly in small sections on treatment areas (such as asthma, epilepsy, anxiety, slimming) with some chapters on more academic grouping of drugs (such as autonomic nervous system, antihistamines and immunosuppressants).

Most of the remainder of the book is an alphabetically arranged pharmacopoeia which describes the actions of drugs in various preparations and agents in current use, their applications in therapeutics and their adverse effects.

The text is clearly written and includes in simple but accurate terms the mechanisms of disease and drug action. The therapeutic advice is very sensible and there is appropriate stress on non-drug treatments.

Of course, not all patients would want to use such a book, but there is no doubt that many people could improve the management of their own illness (such as asthma or hypertension) if they were taught more about the drugs they take and what can be expected of them. In many conditions (such as diabetes, recurrent angioedema and chronic anxiety) it has long been recognised that self-management is essential.

Professor Parish's book may also have a use in protecting the doctor from some types of litigation. Some recent judicial decisions imply that before prescribing a drug, a doctor should tell the patient all the possible adverse reactions of the treatment.

I feel the author is constantly trying to demystify medical practice, perhaps he believes what George Bernard Shaw once said: 'all professions are conspiracies against the laity'.

R G Spector
Emeritus Professor of
Clinical Pharmacology

Neuroanatomy

Neuroanatomy for Medical Students. 2nd edition. J L Wilkinson. Published by Butterworth-Heinemann Ltd. Price £19.95

This book provides an excellent grounding in neuroanatomy, which is so necessary for the student to interpret clinical symptoms and signs in neurological practice. The text is lucid and succinct and not too detailed; and the diagrams and illustrations are well presented. There are some new, excellent photographs/diagrams of transverse sections of the brainstem.

In this current edition many topics have been expanded, particularly those

dealing with functional and applied anatomy. The chapter on the corpus striatum has been updated and now includes the neurotransmitter anatomy of the basal ganglia. There is also a new section on imaging which examines CT, NMR scans and positron emission tomography (PET). The bibliography has been extended, and a useful glossary added.

On the negative side there are no electron micrographs of neurons, synapses, nerve fibres or glia; and some of the light micrographs are of poor quality (eg figs 2.8, 13.8). The functional roles of glia are largely ignored. The index is inconsistent and not exactly user-friendly.

However, despite these minor criticisms I would strongly recommend this book for medical students.

E L Rees
Lecturer in Anatomy

Wilkinson: 'This book provides an excellent grounding in neuroanatomy...'

Snell: 'I would not recommend this publication as a "first book" ... but as an adjuvant to other neuroanatomical texts.'

Neuroanatomy: a review with questions and explanations. Richard S Snell. Publilshed by Churchill Livingstone. Price £16.00

This book is written for medical, dental and paramedical students; and is dedicated by the author to those 'who have difficulty in retaining factual information for neuroanatomy examinations'. Each chapter begins with a plan of learning objectives for a particular topic, and is followed by a condedsed form of factual text with diagrams. It then ends with questions and answers, including explanatory notes.

However, not all the diagrams are simple, some may be bewildering to the students to whom this book is dedicated; in particular, the main conncections of the cerebellum, and the oculomotor nuclei and their central conncections. The questions in the book are of the type required by the American National Board Examinations and do not conform to MCQs used by most universities of the United Kingdom. Despite this, the questions are useful to students in showing areas of weakness in knowledge, and also for the purpose of self assessment.

I would not recommend this publication as a 'first book' or primer in neuroanatomy for undergraduates, but as an adjuvant to other neuroanatomical texts.

E L Rees
Lecturer in Anatomy

Pocket guides

Differential Diagnosis in AIDS—a colour guide. J M Parkin and B S Peters. Published by Wolfe Publishing. Price £10

Whilst the tabloid press debate whether or not there will be an epidemic of HIV and AIDS in this country, the number of people infected continues to rise. If you are a health worker in or around London the odds are that you are already in contact with patients who have this deadly virus.

Differential Diagnosis in AIDS—a colour guide, is not a textbook, but a well illustrated question and answer book that coaxes the reader painlessly through a great deal of up to date information on this new subject which encompasses so much of medicine. I found myself dipping into this manageable book and enjoying the experience. I can thoroughly recommend the text to both doctors and nurses, especially those about to take higher exams.

S Tovey
Consultant in Charge of
Genito-Urinary Medicine

Diagnostic Picture Tests in Endocrinology. 2nd Edition. D C Evered and R Hall. Published by Wolfe. Price £7.95

This compact paperback, in its second edition, and one of some 18 such books in the Wolfe series, contains 215 high quality illustrations of a range of disorders in endocrinology and metabolism, including diabetes mellitus. Each picture is accompanied by a sentence or two of introduction and one or two questions. The answers to these questions and concise relevant discussion is contained in a 22 page section at the end of the book, together with an index. The problems illustrated range from the very common, highly relevant to ordinary clinical practice, to the rare lesion of particular interest to the specialist and to the candidate for MRCP.

Of the 215 pictures, 33 relate to various thyroid disorders, which is probably reasonable considering the importance and frequency of such disorders, but diabetes mellitus rates only 24, less than this also frequent and certainly very important condition deserves in such a book. Overall the balance is well judged. The same can be said for the text, in regard to which I really have only one quibble. In this hospital at least, we are rather unimpressed as to the value of the lateral skull X-ray which is frequently discussed and even recommended in this book. If one needs to know about the pituitary area, one needs to scan, using CT or MRI, to demonstrate the gland itself and the soft tissues around it. Indeed it is surprising that only three CT scans appear in this new edition, and no MRI scans at all. But in general the book is accurate and reliable in its advice. I only spotted one typing error (in question 2G for hyperglycaemia read hypercalcaemia).

I strongly recommend this little volume for those taking MRCP Part II and for endocrine enthusiasts. At least in the library it will also be of interest to those taking Finals. For student use its value is impaired by the fact that a number of the conditions shown are of great rarity; I wonder whether in future editions it would be possible to identify or segregate the more mainline conditions so that undergraduates can be spared the rigours of the 'small print endocrinology'.

B H Hicks
Consultant Endocrinologist

More on PREP

Nurses have been hearing a lot about PREP lately. Those outside the profession, with many years between them and their early education, wonder why nurses are now being set 'homework', or 'prep'—preparation—as it was known in their own schooldays. While the connection may not be entirely invalid, PREP is an acronym for Post Registration Education and Practice. Not a very exciting acronym maybe, but it seems we can't live without them today. Although one wonders whether the acronym sometimes precedes the idea. My personal favourite is FOREST—actually the organisation to protect smokers rights, and I forget what this acronym stands for, but I prefer my own, which is Forget Others' Rights to Enjoy a Smokeless Terrain. Surely this must win acrimonious support from physicians.

I wrote in these columns some months ago when PREP was a project. Now PREP has been projected, farther into the future than the UKCC originally intended, and it will not come into force until at least 1994. Some of the principle objectives of PREP are to identify nurses' needs for updating and maintaining competence beyond initial registration. It is also intended to target additional specific learning requirements. All of this is to benefit patients both within and outside the NHS, thus PREP will ensure a nurse's ability in various ways. Nurses will be expected to record their professional development in a personal professional profile (PPP). A minimum of five days appropriate study leave during each three year period prior to continuing registration will be demanded. If nurses wish to return to practise after a gap of five years or more they will have to complete a 'return to practise' programme. Advanced practitioners will so be expected to show evidence of further Council-approved qualifications or recognition.

All this is directed toward making nursing a more 'professional' career. There are, however, still questions to be asked, and some drawbacks without easy solution; this is undoubtedly why PREP's implementation has been delayed.

Who will verify a nurse's competence? Presumably this will have to be done locally, and may lead to some variability. And who will set the standards? What are the manpower implications? If more study leave is required, will this be permitted, and who will pay, both for the courses and for extra staff needed to fill the spaces posed by those not on duty because they are away on these courses? This, more than anything else, since it involves pecuniary considerations on the part of the Department of Health, has been a reason for setting back the starting date for PREP. Those working outside the NHS may find even greater problems in enroling for study, and maintaining their registration. Inevitably this cost has already led to forecasts that fewer nurses will be employed in the future, their places being filled by health care assistants with a lower price tag.

It is possibly true that nurses who already take the most professional attitude to their job, fulfil the requirements of PREP now. What of those who, for a variety of personal and legitimate reasons, will find that PREP presents difficulties?

There are some disadvantages and it is important that nurses are both aware of them and discuss them before PREP imposes the statutory requirements. Nurses

educated under the Project 2000 scheme will be prepared for the fact that a degree qualification at the end is not final. Indeed I well remember the matron of my old training school, who on congratulating us for passing 'finals', asserted that this was not final and our learning was just about to begin. Even if we and the statutory authorities did not agree then, we soon discovered how right she was!

The UKCC does reassure nurses that 'all learning, including that acquired through clinical experience, should also receive credit'. However a proper explanation must be given to all nurses about what PREP entails. Finally, we must keep on paying our fees, and accept this or lose our registration.

Denis Cobell

PHYSIOTHERAPY NOTES

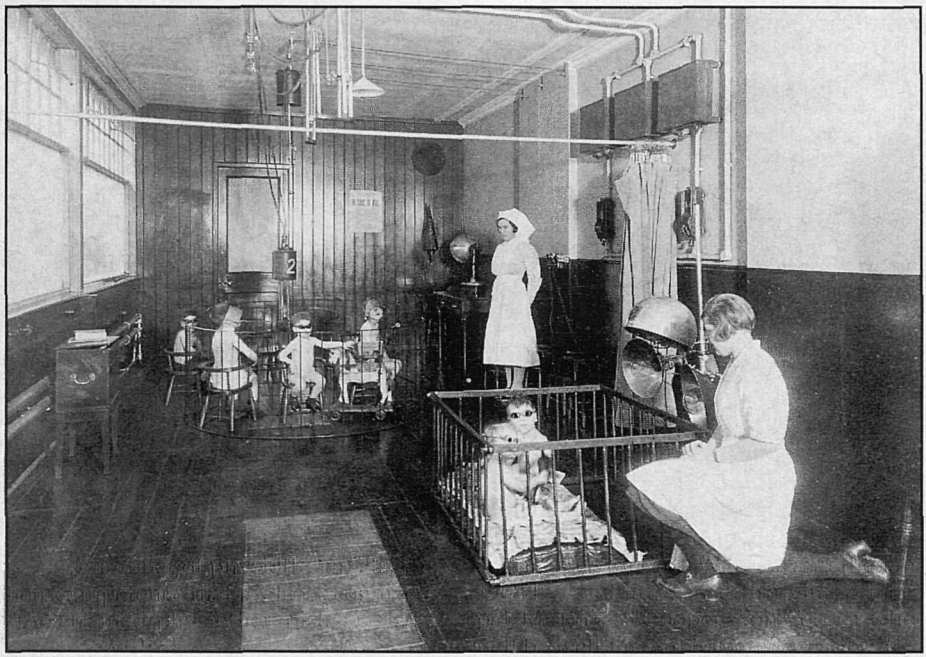
A potted history 1913-1992

Over the past three academic years Guy's Hospital School of Physiotherapy has been closing and during this period just under 100 students have qualified from the newly-validated Guy's course in three cohorts. These last students have acquitted themselves well and been highly successful in all aspects of their training.

It is interesting to compare these students with the first 100 or so students at the then Guy's School of Massage. It is not easy to be entirely accurate about this because records are not always complete and recorders are fallible. Although massage was taught at Guy's as far back as the late 1880s, the present School of Physiotherapy really dates from the foundation of the School of Massage in 1913.

WHIRLPOOL BATH TREATMENT

In the massage department at Guy's Hospital this immersion treatment is administered to infants whose limbs are wasted through disease or injury. The whirling stream is hotter than the rest of the water and is driven forcibly through nozzles.



The record of each of these early students, written in the firm recognisable hand of the first Principal Miss Angove, started in 1914. The first 100 or so students who appear to have done courses of various lengths entered the school during 1914-16. These records are evocative; serious sepia faces stare, sometimes glower, at one from the tiny cut-out photograph on the upper right-hand corners of the fragile foxed cards. Date of entry, date of passing anatomy, date of passing massage, all carefully noted. Most striking of all are the comments, written with alarming frankness and displaying open prejudices which sit uncomfortably with modern social mores. There is strong concern for manners and attitude.

'Work on the whole good, manner off hand—requires discipline', or 'very good to patients, very common type'. A distinct briskness, even brusqueness, is evident in all the comments both laudatory and derogatory. 'Good massage, not reliable' and the uncompromising, 'very stupid, does not concentrate'. Phrases and concepts from an earlier age appear, reminiscent of conversations with grandparents, such as references to people being 'highly strung' and other judgements less suitable for publication.

What were the recipients of such comments really like? They were certainly not youngsters, for these students of the early days were mainly mature women, often experienced nurses. In fact the average age of the first 100 students was just over 30 years and they ranged from 18 (of

which there appeared to be only one) to 56! In contrast, the last three cohorts of physiotherapy students have an average age of about 20.6 years, and range from 17 to 37 years on entry; about one sixth of them being male.

The number of students qualifying in the early days seems high, but it must be remembered that the course was shorter, in fact almost exactly the same number of students entered the school between 1914 and 1946 as have entered in the 46 years since. The First World War had stimulated increases in training which led to the School expanding and ultimately being sited in the newly built Shepherd's House during 1921 where it has essentially remained ever since. The Electrical and X-Ray Schools were formed at Guy's in 1927 and some nine years later the electrical part united with the School of Massage.

Until this time, 1936, Miss Angove had been the only Principal. It is from this period of the 1920s and 1930s that the photographs derive. They attempt to give a flavour of the times, and the rather static poses were dictated by the need to have fairly lengthy exposure times.

Over the 79 years of its existence the School has had some 3,285 students, and of these approximately 2,760 (84%) have qualified. Over the years this is an average rate of almost 35 per year, although the actual rate was higher in the earlier years. Since 1914 some 48,000 physiotherapists have qualified in the UK, so Guy's has contributed a little under 6% of the total; a significant achievement in terms of quantity alone. However, it is not

only the number of physiotherapists, it is their competence that is also recognized; Guy's trained physiotherapists are to be found at work all over the world.

It is not only clinical physiotherapists that have trained here at Guy's over these 79 years. The first Principal was particularly interested in training teachers of physiotherapy and this emphasis continued in the succeeding years. National lists of school principals, course leaders or heads of school have often echoed lists of Guy's student teachers from previous decades. Miss Angove also set a precedent for longevity in post; after some 22 years she was succeeded by Miss Evans who served for 23 years, taking the School through the difficult years of the Second World War and the adjustments needed for a new course in 1947. This course combined the old separate massage remedial exercises and electrotherapy into 'physiotherapy'. When Miss Evans retired in 1959 she was replaced by Miss Tanner and in 1963 by Miss Watkins and then in 1968 by the third-longest serving principal, Mr Ronald Cooper. Ron Cooper who will be well-known to *Gazette* readers for his regular, readable and perceptive contributions, managed the School for 20 years until his retirement in 1988. He is fondly remembered by generations of students for his firm friendly leadership and intellectual skills. He is also the author of an account of the School of Physiotherapy in *Guy's Hospital 250 years* published in 1976 from which the writer has drawn.

So the very last group of Guy's physiotherapy students will attend the very last graduation ceremony on 31 October 1992 having achieved a 100% pass in their final examinations. Perhaps they collectively also deserve the first principal's brisk accolade for a 1917 student: 'very good in every way'.

John Low
Principal

Rugby Club fixtures1992-93

First XV fixtures

3 Oct* Cranleigh 3pm Home
10 Oct* Portsmouth 3pm Away
11 Oct UH Hospital 7s 10.30am (at London Welsh)
17 Oct Freshers' Tour
18 Oct UH Trials 2pm (at St Mary's)
24 Oct* Old Walcountians 3pm Home
31 Oct* Alton 3pm Away

7 Nov Bec OB 2.45pm Away
14 Nov* Eastleigh 2.30pm Home
21 Nov* Jersey 2.30pm Away
28 Nov Rosslyn Park III 2.30pm Home

5 Dec Chichester 2.30pm Away
12 Dec Shirley Wand 2.30pm Away
19 Dec Blackheath III 2.30pm Home

2 Jan Streatham/Croydon 2.30pm Away
9 Jan* Winchester 2.15pm Home
13 Jan Esher 6.30pm Away
16 Jan Westcombe Park 10.30am Away
23 Jan Old Beccelamians 2.30pm Away
30 Jan Cardiff Medicals 2.30pm Home

6 Feb Raynes Park 12 noon Away
13 Feb* Purley 2.30pm Away
20 Feb Bromley 2.45pm Home
27 Feb Effingham 2.45pm (at Cobham)

6 Mar Askeans II 10.30am Away
13 Mar* Millbrook 3pm Home
20 Mar Old Reigatians 12 noon Home
21 Mar Past XV 3pm
27 Mar* Old Wimbledonians 3pm Away

3 Apr* Warlingham 3pm Home
10 Apr Easter Tour
25 Apr 10s Tournament (at Barts)

* Courage League match

Second XV fixtures

3 Oct Cranleigh 3pm Away
10 Oct Rosslyn Park 3pm Away
24 Oct Old Walcountians 3pm Away
31 Oct London Irish EXA 3pm Away

7 Nov Bec OB 2.45pm Home
14 Nov Southend 2.30 Away
21 Nov St Mary's Bs2.30pm Home
28 Nov Blackheath IV 2.30pm Away

5 Dec Chichester 2.30pm Away
12 Dec Met Police III 2.30pm Away
19 Dec Blackheath IV 2.30pm Away

9 Jan Old Emanuel 2.15pm Away
16 Jan Old Blues 10.30am Away
23 Jan Citizens I 2.30pm Home
30 Jan Meadhurst 2.30pm Home

6 Feb Old Alleynians 12 noon Away
13 Feb Purley 2.30pm Home
20 Feb Bromley 2.45pm Away
27 Feb London 2.45pm Away

6 Mar Barts II 10.30am Home
13 Mar Sittingbourne 3pm Away
20 Mar Old Reigatians 12 noon Away
21 Mar Past XV 3pm
27 Mar Streatham/Croydon II 3pm

3 Apr Warlingham 3pm Home

New Dentists

The following students qualified BDS (London) in June 1992 and are life members of the United Clubs.

Gillett, Miss J E
Hallows, Miss R C
McDonogh, T P S
O'Brien, T P
Pathmanayagam, Miss S
Peck, Miss E D
Powell, D C
Qureshi, Miss N
Sarwar, M N
Small, C T W
Sowerby, Miss N J

The following qualified LDS in March 1992

Ching, L Y K
Chock, Y F
Earl, T J
Gillet, Miss J E
Hallows, Miss R C
McDonogh, T P S
Qureshi, Miss N
Small, C T W
Sowerby, Miss N J

Birth

HENDERSON, at Friarage Hospital, Northallerton on July 11 to Richard and Jane. A daughter, Harriet Clare Edith, a sister for Eleanor.

Death

HARDING—Harold E, retired pathologist of Salisbury Infirmary, died suddenly on July 16 at the ripe old age of 93 years.

Thanks

The following have contributed to the Dental School Centenary Appeal in memory of Mr E A J Bradley who qualified from Guy's in 1928.

Mr and Mrs Ray Lance

Mr and Mrs A J Parrott

Mr Cyril Bristow—on behalf of the Kent Cyclist Battalion Old Comrades Association

Mr and Mrs Alan Brown

Thanks also to Mr N J Chadwick for a donation of £500 to the Dental School Centenary Fund in memory of Mr J F Pilbeam and Mrs A F L Pilbeam of Tunbridge Wells.

Correction

Apologies to Mr Ronald Cooper for the typographical errors which appeared in the transcript of his speech in the September issue. 1969 is not the 47th year of the School of Physiotherapy which started in 1913, but 1960 is! Oops!

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GUY'S HOSPITAL GAZETTE
November 1992

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- EMSA—what it's all about
- Sherlock Holmes—the art of medical diagnosis
- Facilities Management—a new column

Following the Tomlinson report, new accommodation is being prepared in China Town, Kuala Lumpur beneath a large dental clinic.
(**Photo:** Professor A H R Rowe).

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UMDS
18 NOV 1992
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Guy's Gazette

Editor Fuad F Hussain **Sub Editor** Laurence Reed **News Editors** Shahid Khan, Robert Self **Sports Editors** Abhimanu Lall, Philip Marino **Physiotherapy** Diana Innocenti **Nursing** Denis Cobell **Office Manager** Margaret Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

Sir Bernard Tomlinson's report is the talk of the town this month. The hospitals concerned are busily taking evasive action in order to ensure survival when the government finally decides which of the recommendations to act upon.

There is certain sense of the NIMBY syndrome that can be detected; (NIMBY for those not in the know means 'Not In My Back Yard'). Almost without exception everyone accepts that changes are needed in the organization of London healthcare facilities. Likewise, almost without exception, most parties would prefer not to be affected by the changes. Guy's and St Thomas's had anticipated some of the report, and to that effect are continuing the process of increased co-operation. It seems that ultimately this will have to lead to a merged hospital on one or other site. The official position is that the Guy's and Lewisham Trust will accept any decision provided it is well-considered and in the interests of the patients. Unofficially, no doubt, each site has its own protagonists.

Speculation before Tomlinson strongly suggested that St Thomas's would be named as the hospital to close. Everyone at Guy's seemed confident, possibly even complacent; there is not even a 'Save Guy's' campaign that I am aware of. It is not really surprising if some of the staff feel 'betrayed' by the government for building up Guy's as the 'flagship Trust' if its very future is now open to question. However, as one consultant who was speaking to us remarked, being the flagship is no guarantee against closure. After all, what better way of demonstrating the government's commitment to ensuring the best solution for London than by sacrificing its 'most precious son' if that is what is required. Others at Guy's are convinced that it would not be possible for MPs to decide to close the hospital that stares at them from the other side of the River. 'But they can't close down Guy's—they've almost finished McDonalds,' remarked one student. 'They can—it'll just be the world's largest McDonalds,' came the worldy reply.

The site is still uncertain, but the merger is inevitable. What of a name? Well, a suggestion from the *Bridge* is St Thigh's. In a similar vein, a reader suggests a new name if the medical school combines with King's: South London United Medical Schools—or SLUMS for short!

Philistine's Hospital?

Dear Sir,
The months go by, the government continues its relentless dismemberment of the NHS and what do we hear from Guy's—nothing!

It is a foregone conclusion that St Bartholomew's, St Thomas's and the Middlesex would be in the forefront of the threat of annihilation because, in terms of valuable sites, they are the pick of the crop. Evidently three more Canary Wharves are contemplated—just what we need for our moribund economy. With the capital, possibly illegally, realized from the sale of these sites, assuming that it remains at the disposal of the NHS, no doubt more and more bureaucrats and their expensive equipment will be acquired.

Are the clinical staff at Guy's all so afraid of their semi-literate managers that they dare not speak up? Are the consultants, with one eye ever upon the prospect of Honours, so busy coining the lucre in private practice that they have no time or inclination to oppose the disgraceful plunder of our heritage? Are the students—medical, dental and nursing—so burdened by the prospects for their future that they are disinclined to raise even a ripple, let alone a wave of protest?

May I suggest that the name of Guy's be spared further ignominy and that it should be changed to something more appropriate—Philistine's Hospital perhaps.

Yours faithfully,

B A TUDGAY
Broomden
Ticehurst
Wadhurst
East Sussex TN5 7LP

Fripp and the Frothblowers

Dear Sir,
I enjoyed reading the lectures of Sir Alfred Fripp on the 'Art of Living', still largely relevant after 70 years.

Fripp was I believe the founder of that esoteric society, the Ancient Order of Frothblowers, a sort of early CAMRA. Frothblowers had their rituals, and members greeted each other at the bar by shooting their AOFB cuff links, and one caught without them had to stand a round. There was a hierarchy of titles earned by the number of new members enrolled, from the Gentle Zephyr up to the Grand Tornado, and large sums of money were raised for charity.

I still have the links belonging to my father (Guy's 1905) and I was delighted to meet recently in a Scottish hotel another guest who was wearing them. Alas I was not.

Beer must have been headier in those days.

Yours faithfully,

M S M PALMER
24 Matham Road
East Molesey
Surrey
KT8 0SU

1926 House officers

Dear Sir,
I wonder whether in the hospital archives there are lists of the house officers? I have one myself that I helped myself to, when it was obsolete in 1927.

I have a photograph of the 'Niggers' in December 1926; that is the date I am interested in. I am able to name all save four of the then residents.

Yours faithfully,

GEORGE WESTON
115 Parkanaur Avenue
Thorpe Bay
Essex
SS1 3JD

Merged boat clubs?

Dear Sir,

The boat clubs of Guy's and St Thomas's Hospital, whether amalgamated, seperate or semi-amalgamated have been the only club within UMDS to continue to operate separately. The Rugby Club operates as one club with only the name changing between the Wednesday fixture and the Saturday fixture, but always involving all interested students. All other clubs seem to be quite happy to play as a UMDS side, so why not the boat clubs?

Messers Robin and Cash's rather childish and slanderous letter in last month's *Gazette* seems rather inappropriate now we know the results of the Tomlinson report. It seems very likely that most of its recommendations are likely to become Government policy within six months.

So with the amalgamation of the medical schools having reached its 10th successful year and the likely amalgamation of the hospitals, isn't it time the boat clubs put away old petty campus loyalties and started using their facilities at ULU boat house and the Tideway, as well as their combined skull and equipment to best use, to produce a boat club welcoming all students and producing rowing squads at all levels that will and are capable of beating other London medical schools and rowing clubs.

Yours faithfully,

RICHARD PROBERT
UMDS Student President
St Thomas's Campus
London SE1 7EH

Reflections on Life

This is a story about four people named *Everybody, Somebody, Anybody and Nobody*. There was an important job to be done and *Everybody* was sure that *Somebody* would do it. *Anybody* could have done the job but *Nobody* did. *Somebody* angry about that because it was *Everybody's* job. *Everybody* thought that *Anybody* could do it but *Nobody* realized that *Everybody* wouldn't do it.

So it ended up that *Everybody* blamed *Somebody* when *Nobody* did what *Anybody* could have done!

SM

Research Day

Research Day this year took place on 23 September, and marked the 10th anniversary of the formation of UMDS. During this time, there has been the stimulus to much new research activity and an increase in the value of the research grants awarded.

As a reflection of this success, both morning and afternoon sessions were well attended. Guests included the Secretary of State for Health, Virginia Bottomley.

Hib vaccine

From October 1, this new vaccine has been added to the immunization schedule. It consists of three doses, taken at two, three and four months.

7 to 11 month olds are most at risk from *Haemophilus influenzae* type b infection, which is one of the causative organisms of bacterial meningitis and epiglottitis.

Retirement

Noreen Clare came to Guy's in May 1974 when she joined the staff of the Oral and Maxillo-facial Department as Senior Dental Nurse in Dental Casualty (later named the Primary Treatment Unit). It immediately became apparent that we had acquired another great personality.

No words can adequately express her very many qualities, but the first on the list must be that of loyalty. She will be remembered with respect and affection by many DSAs and dental students who all had to conform to her very high standards.

After the dental hospital moved to the Tower, Noreen was very much in charge of Floor 23. Her ability to organize and get things done resulted from her knowing practically everyone of importance in the hospital and ensured that she was later appointed to a newly created post best described as Floor Manager.

Her attention to detail, punctuality and cleanliness were all instilled with a fearless authority and formed a very important aspect of DSA and student teaching. At all times she was a fervent supporter of all who had to work with her but woe betide anybody who thought they could do it their way.

Guy's has lost one of its best workers but we will never forget and always remember her for her friendship, kindness and love of life. Noreen retires on 30 November 1992 and all who have been associated with Noreen wish her and Ken very many years of happy retirement.

RAS and PMO'D

Noreen Clare

Bleeps for parents

The Evelina Children's Family Trust is helping relieve the anxiety for parents of children with serious illnesses by providing them with pagers that can immediately alert them to changes in their childs condition.

Parents can sometimes feel very worried and reluctant to leave their child's bedside, even for a few moments, just in case there is some deterioration in the child's condition. Parents can now take a rest, without forever fearing the worst scenario of something happening without them knowing about it.

Health care seminars

A series of interactive seminars on issues in health care today have been organized primarily for the benefit of medical and nursing students, though all members of staff are welcome to attend. They are held at 5pm, in the Nevin Lecture Theatre at St Thomas's on Mondays, and the topic is repeated in the Harris Theatre at Guy's the following Thursday.

A topic is presented from two opposing viewpoints by the speakers, and the audience are then invited to join in the debate. It provides an opportunity to learn, discuss with, and present ideas to peers and seniors in a frank and open forum. Some of the topics to be discussed are: *Ethics and the Health Service Manager* on 12 November, and in the following weeks: *Professional freedom is under attack from audit and management structures, Alternative medicine—to audit or ignore* and *Sacking the slackers protects the patients.*

Certainly, the first of these was not well attended on either campus, which is an unfortunate waste of time for the busy clinicans who present the seminars. Perhaps attendance would be improved by a different time slot, or mention of refreshments?

Students killed

It is with great sadness that the *Gazette* has to report the deaths of James Hawker and Alex Boulger. They died in a minibus accident of Friday 16 October at the start of the rugby tour. Our deepest sympathy goes to their families and friends.

Tomlinson report

Provisional details about the recommendation of Sir Bernard Tomlinson have just become available. The Government is not due to decide immediately which of the changes to enact, but rather a period of consultation should precede the final decision to be made known at the start of next year.

It had been widely speculated that Guy's and St Thomas's would be looking towards a future of much closer co-operation at the hospital as well as the medical school level, and this has indeed been borne out in the Tomlinson Report.

The plan favoured by UMDS is to gradually implement changes, initially by locating acute services on one of the sites and elective facilities on the other which could also accommodate academic and research facilities. Further afield, plans would also have to consider the nature of the association between UMDS and King's College.

Nursery at Guy's

Childcare facilities at Guy's have long been neglected. This unacceptable state of affairs is to be corrected by 2 November when the Guy's Hospital Nursery is to open. The nursery will have places available for only 41 children and is being staffed by nursery nurses and trained assistants.

The fees vary from £55 to £85 per week based on a scale of earnings from £10,000 to £30,000 and will be automatically deducted from salaries.

McDonald's has extended a support grant for this project as part of the contract for their restaurant to open on the Keat's Dining Room site in December.

Bridging the gap

Nobody at Guy's could have failed to notice the 1st issue of the *Bridge*. This editorially independent newspaper of the Guy's and Lewisham NHS Trust is being produced to serve as an organ of communication within the Trust. Communication *is* the important concept, since not only does the Trust want to inform and update all those associated in any capacity with the running of Guy's and Lewisham, but no doubt the staff and students would like a forum in which to air concerns, comments and criticism. To this effect letters can be printed anonymously.

First impressions have been largely favourable, though one of the aims is to do a more formal survey of how the *Bridge* has been greeted.

The *Bridge* is an A4 format 'newspaper' which was initially to be produced quarterly. The next issue is due out around Christmas, and future plans may include an issue every two months. 10,000 of the first issue were printed, and distributed around the Guy's, Lewisham and New Cross Mental Health Unit sites. Although exact figures are not available, the projected cost of production for one year is £40,000; although this will be offset by the advertising income. The costs are being met by the Special Trustees.

Classifieds and Announcements

The *Gazette* is pleased to publish classified advertisements. These are charged at the rate of 10 pence per word—money with order please. It is helpful if you can include a contact telephone number in case of any queries.

Announcements of births, deaths and changes of address will be published free of charge.

Please ensure that these items reach the *Gazette* office four weeks prior to publication.

The European Medical Students' Association

Everything you always wanted to know about EMSA but were afraid to ask

EMSA is a young organization formed at the 1990 European conference for medical students in Brussels. EMSA became legally established at the September 1991 General Assembly in Brussels, which was supported by the EEC. It is an organization run by medical students for medical students. Our aim is to increase contact between medical students and their faculties throughout the whole of Europe at educational, cultural and social levels, and hence to see medicine from a wider perspective.

Our activities for the year include:

- Education: Representation or observer status on European educational and medical bodies, clinical and pre-clinical exchanges.
- Travel: Where do you want to go?... Prague, Barcelona, Berlin...
- Summer schools in Turkey, sports weekends, inter-rail, social visits...
- Medical languages: Books and courses—weekend, evening or intensive weeks abroad.
- Medicine and science: EISS (our scientific symposium) in Amsterdam, research grants, experimental surgery society, oncology in Sweden with EACE, *JEMSA*—a scientific journal in which students can publish their research.
- Literature: The bi-monthly official courier to keep in touch across Europe, quarterly magazines on topics such as ethics, the EMSA information centre.

EMSA at UMDS

Several UMDS students attended the EMSA UK South East region 'Eurotalk' weekend at UMDS in May, along with 60 medical students from the rest of the UK. Medical French language was taught with the invaluable help of Mrs Band, a professional medical translator, 15 French medical students from Lille, UMDS's twinned medical school, with their English tutor, and some

French ERASMUS students. Dr Thomas, the Pre-clinical Dean, and Mr Brueton, an orthopaedic surgeon, kindly talked to us. A delicious French lunch (French cheeses, wine and baguettes) was generously sponsored by the BMA. The European Bookshop had a display of books for us to browse through. Students from Lille will be back to UMDS this year for a sports weekend in October arranged by UMDS, following an enjoyable visit by our sports teams to Lille last March.

The Eurotalk weekend was intended as a kickstart for the learning of medical French; since then we have had several requests from UMDS and other London students for medical French evening classes, as well as evening classes in other languages. Medical French evening classes are available at the Royal College of Physicians in conjunction with the French Institute. Medical language classes with flexible tutorials are available at City University. If you are interested, please contact Chris or myself as soon as possible. Simon Thompson has contacted the Morley College and South Bank University about language evening classes. Please contact him for further details. Medical French-English books similar to the book used on the course will be available from December, and will be translated into German and Spanish later in the year. UMDS have also arranged a one year foreign language diploma course at the South Bank University. For further details, please contact Dr Thomas.

Several students from UMDS have attended other EMSA events during 1991-92, including the summer schools in Turkey on maternal and child health, drug care or primary health care; the French and Spanish Eurotalk in Sheffield, the EMSA UK National Assembly in Glasgow, and the EMSA General Assemblies in Brussels and Barcelona. We hope that even more of you will become involved in EMSA this year.

Elections for the new EMSA reps will be held on 20 October. If you would like to stand, or want further information about EMSA's activities this year, or if you would like to help in any way (EMSA is an organization run by medical students for medical students!) please contact the following students:

BSc year: Chris Muller-Pollard (Tel 378 6502)
3rd year: Maxine Patel, Louise Ward (Tel 252 6185)
4th year: Fiona Arnold, William Kuteesa (Tel 403 3578)

Even better, come to the EMSA UK National Assembly on November 7-8 (Guy Fawkes Weekend), co-hosted by UMDS and St Bartholomew's Medical School.

Many thanks to UMDS for all the support they have given EMSA through the year.

Fiona Arnold

Guy's Dental School and Candida albicans

Thrush of a distinctly unfeathered kind!

Oral candidosis is a frequent and early manifestation of disease associated with the human immunodeficiency virus (HIV)[1], and has been reported in almost 90% of patients with acquired immunodefiency syndrome (AIDS)[2]. It is now evident that oral candidosis is not only a prominent early indicator of HIV infection but also a good prognostic indicator of eventual progression to AIDS[3]. The best known and by far the most common pathogen of oral candidosis is *Candida albicans* , although other species, such as *C glabrata*, and *C tropicalis* are infrequently isolated from oral lesions.

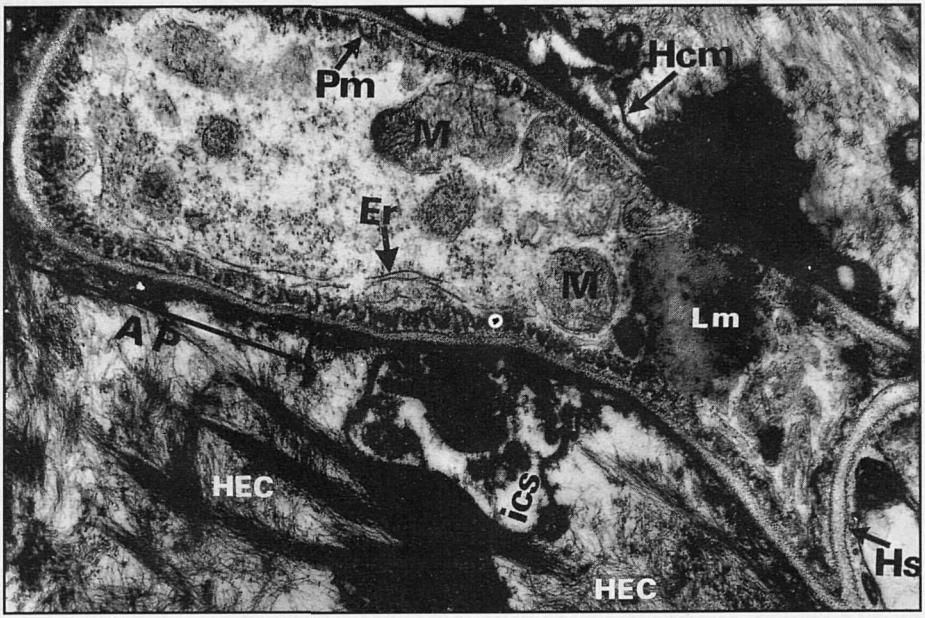
Guy's Hospital Dental School has a long-standing 'connection' with *C albicans*—the causative organism of oral candidosis (thrush). It dates back to 1966 when Thomas Lehner (now Professor and Director of Immunology at Guy's), as senior lecturer in the then department of Dental Medicine, (now the department of Oral Medicine and Pathology), first classified superficial infections of oral candidosis into four varieties.

Acute pseudomembranous candidosis: this is the most common form of oral candidosis, commonly referred to as thrush, seen in infants and adults. It can be seen as white papules or 'cotton wool' exudates which can be scraped off leaving an erythematous mucosa. In severe cases the entire oral cavity man be involved.

Acute atrophic candidosis: this may follow acute pseudomembranous candidosis. It is usually associated with broad spectrum antibiotic therapy and sometimes referred to as 'antibiotic sore tongue'. It is consistently painful showing a smooth erythematous tongue.

Chronicatrophic candidosis (denture sore mouth): known as 'denture stomatitis' for it is seen as a diffuse erythema of the palate limited to denture-bearing mucosa.

Chronic oral hyperplastic candidosis: a less common type of candidosis, presenting as a firm white patch which cannot be rubbed or scraped off, and which commonly affects the tongue, cheeks and lips. This type of lesion may

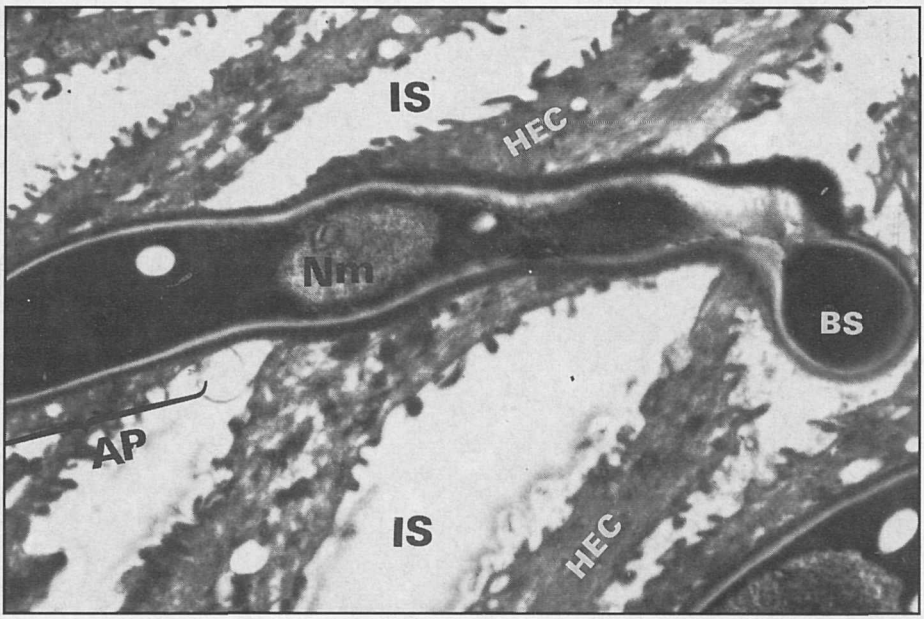


Transmission electron micrograph of an invasive end of a mature hypha of *C albicans* within oral epithelial cells. (HIV negative). Well differentialted tonofilaments within oral epithelial cells (HEC); intercellular space (ics); mitochondria (M); endoplasmic reticulum (Er); hyphal septum (Hs); ruptured host cell membrane (Hcm); lipid material (Lm); plasma membrane (Pm); appressorium (AP). x30,000.

persist for years and is resistant to antimycotic treatment. It has been referred to as 'Candidal leukoplakia'.

During the same period as Lehner's classification began to appear in medical journals and text books around the globe, Roderick Cawson, (now Emeritus Professor of Oral Medicine and Pathology), as Reader in the then Department of Dental Medicine, put forward detailed accounts of the histopathology of oral candidosis and then divided the oral infections of candidosis into two types on histopathological grounds. The acute form is represented by 'thrush', and the chronic form by 'Candidal leukoplakia'. Lehner's and Cawson's classification is well recognised and holds good to this day.

In more recent years Professor Stephen Challacombe (1991) head of the Department of Oral Medicine, Pathology and Oral Microbiology at UMDS,



Transmission electron micrograph of a young hypha of *C albicans* invading host epithelial cells. (HIV positive). Blastospore (BS); nuclear material of young hypha (Nm); host epithelial cell with diffuse tonofilaments (Hec); intercellular space (ics); appressorium (AP). x16,000.

incorporated a further type of candidosis—chronic erythematous candidosis: this is a red area without removable plaques, often located on the palate, the dorsum of the tongue and buccal mucosa. Frequently associated with HIV infections, the recognition of this additional type of candidosis has now made Lehner's (1966) original classification into five varieties.

Later in 1991, the author (KCR) of this article, presenting his PhD thesis made some interesting findings in relation to the processes invoved in the invasion of *C albicans* in both oral and vaginal candidosis. It is now believed that *C albicans* resorts to at least three different invasive processes: firstly, an enzymatic process brought about by the production of hydrolytic enzymes (acid phosphatases, proteinases and phospholipases); secondly, a 'physical' process suggested by the presence of an appressorium in the invasive end of the hypha; and thirdly a 'mechanical' process effected by the presence of fine

'fibrillae' structures that emerge from the outer surface of the invasive fungal cell wall.

With the recent establishment of the UK Oral AIDS Centre, within the Department of Oral Medicine and Pathology, under the chairmanship of Professor Challacombe, more research has been gaining momentum. Thus it its fitting to conclude that the 'connection' of *C albicans* with Guy's Hospital Dental School is growing stronger and appears to pave the way for futher important findings in this field.

K C Rajasingham
Department of Oral Medicine and Pathology

1 Samaranayake and Holmstrup 1989
2 Pheland *et al* 1987; Quart 1992
3 Samaranayake and Scully 1989

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Do We See But Not Observe?

Sherlock Holmes and the art of medical diagnosis

Sherlock Holmes has inspired and stimulated the medical profession probably more than any other fictional character, not least because his adventures reflect so well and describe so vividly contemporary Victorian and Edwardian medicine. This is largely a result of the medical training and experiences of Dr John H Watson and his literary agent, Sir Arthur Conan Doyle, and it is well-known, for instance, that Doyle was greatly influenced in his creation of Holmes by Dr Joseph Bell, one of his teachers at medical school, whom he said had an 'eerie trick of spotting details. If he were a detective, he would surely reduce this fascinating, but unorganized business into something nearer to an exact science'.[1] In addition, Holmes may have been named after a Dr Oliver Wendell Holmes of Boston,[2] and within the 60 Holmes stories there are references to 68 diseases, 32 medical terms, 38 doctors, 22 drugs, 12 medical specialties, six hospitals, three medical journals and two medical schools.[3] Sherlock Holmes has even been discussed previously in the *Guy's Hospital Gazette*, in a series of ten articles by the late Sir Maurice Campbell between 26 April 1980 and 26 September 1981;[4] this remains one of the most thorough and interesting discussions of the medical content of the Canon seen anywhere.

Given this clear association between Holmes and medicine, I thought it might be interesting to see what the art of diagnosis might gain from Sherlock's methods. To do this, I shall concentrate on a series of papers recently published in the *Journal of the Royal Society of Medicine* (*JRSM*),[5-8] although such discussion is far from new.[9-16] The reader may further be interested to know that all papers pertaining to Holmes in the world medical literature since 1966 have recently been reviewed.[17]

In January 1989, Peschel and Peschel published an article in the *JRSM* considering what physicians have in common with Sherlock Holmes.[5] They commented that medical and detective work share a number of thought processes and drives, namely observation, analysis and deduction, devotion to detail, hard work, learning, energy, determination, and an overpowering

desire to solve mysteries. They then illustrated, by means of three medical case reports, how an application of Holmes's methods could benefit hospital practice, and used a jigsaw puzzle analogy to illustrate how in the diagnosis of an illness one often does not have all the pieces. The key role of observation in medical diagnosis was well illustrated in a letter by Nusynowitz to the *Journal of the American Medical Association* in 1969.[11] Nusynowitz recounted the case of a drug company representative with acromegaly, who over a period of five years saw more than 10,000 physicians. Unluckily for him, however, none of them spotted his problem, and Dr Nusynowitz thus concluded how, despite the sophistication of modern medical equipment, the eyeball, properly used, remains an excellent diagnostic tool!

A further article in the *JRSM* by Oderwald and Sebus two years later continued the discussion, with particular attention given to the problem-solving aspect.[6] They criticised the Peschels' jigsaw puzzle analogy, proposing that such a metaphor arises from the neat pre-ordained nature of detective stories and medical case histories, in which a known outcome results in a reversal of time. To understand medicine in practice, they argued, one has to distinguish between what is happening in reality and the specific way in which reality is represented in a case history. Thus, final success should not be ascribed to the entire diagnostic process, nor should reality be reduced to one line of reasoning. They proposed Umberto Eco's novel *The Name of the Rose* (1984) as a better analogy of detection to medicine.[18]

In this novel, the protagonist, coincidentally (?) named William of Baskerville, attempts to solve a series of murders in a monastery, the plot consisting of several parallel levels. Only one of these levels concerns detection per se, such that, despite William assuming a theological pattern to lead him to the solution, this turns out to be the wrong pattern, with the outcome not the result of what he thought. Rather, his mere presence at the scene seems to be more important. In addition, at the end of Eco's novel, there is no 'complete picture', but instead an open structure, which Oderwald and Sebus proposed as more analogous to medical practice than the jigsaw puzzle model. Certainly, it would be counter-productive to believe that a narrow line of reasoning could cope with the multifactorial nature of medical diagnosis and management.

In a subsequent letter to the *JRSM*, Ayers supported Oderwald and Sebus's William of Baskerville model of medicine,[7] and referred to the enunciation by Eco and collaborators (1983) of the principles of ratiocination (Edgar Allan Poe's term) or abduction (Eco's preferred term), which are:[19] 'Never assume anything; the nature of the object under scrutiny must dictate the nature of the inquiry; it is necessary to keep sight of the matter as a whole; and one must prove that crucial "apparent impossibilities" are possible (if, indeed, they are

so)'. This is surely the best representation yet of Holmes's methods, and how they can be transposed to medical practice. Ayers concluded by saying that current work on computer algorithms and artificial intelligence as a means of handling medical decision making might prove to be a waste of time, and even counter-productive,[see 20] with the answers all in Sherlock's methods.

Detective story versus medical case history

Finally, in the June 1992 issue of the *JRSM*,[8] the Canadian anthropologist Joel Wilbush criticised the Peschels' use of Holmes's methods as a model for the diagnostic process,[5] even when a multi-levelled approach is adopted.[6] He argued that unlike a detective identifying unknown agents, a doctor usually knows his patient and likely disease scenarios, and is thus able to make diagnoses *'like a blacktracker identifying spoor left by a familiar animal'*, rather than by deductive analysis! He concluded that the role of older more primitive parts of the brain in the diagnostic process remain under-appreciated.

Whilst interesting, Wilbush's comments are perhaps not surprising from an anthropologist, and can easily be criticised; few would argue, for instance, that 'instinct without knowledge' could recognise dysdiadochokinesia or diagnose phaeochromocytoma. Nevertheless, he does have a point in that medicine is much more than just a series of deductive steps, and unlike detection, for instance, management in medicine begins rather than ends with the diagnosis. In this regard, it is notable that Sir Arthur Conan Doyle himself thought that Holmesian methods were unsuitable for medicine, and in an address in 1910 to students at St Mary's Hospital on 'The Romance of Medicine', he warned against undue materialism and intellectual priggishness, and said that he had 'known men in the profession who were stuffed with accurate knowledge, and yet were so cold in their bearing, and so unsympathetic in their attitude ... that they left their half-frozen patients all the worse for their contact'.[21] He emphasized 'the value of kindliness and humanity as well as of knowledge'. More recently, a report in *The Times* (22 April 1981) stated that 'if the doctor becomes a medical Sherlock Holmes ... the patient may feel that he has ceased to be a person and has become a case'.

Despite being true, these views, firmly rooted in the principles of holism, are I believe rather unfair on Sherlock Holmes, who selected interesting cases 'for the quick analysis of cause and effect which gives the charm to an investigation'. When asked by Watson in the story *A Case of Identity* how many cases he had on hand, for example, Holmes replied: 'Some 10 or 12, but none which present any feature of interest'. In other words, deductive analysis, though interesting for the reader, played little part in most of Holmes's cases.

I would propose that this is also true for medicine, however much we may like to think otherwise!

John S Gilbody

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Anglo-French Rheumatology

UMDS and CHRU de Lille—first liasons

The first ever joint meeting between the Rheumatology Units of UMDS and CHRU de Lille, France, took place on the 29 May 1992. We welcomed our visitors Professor B Delcambre, Professor B Duquesnoy and Dr R-M Flipo to Guy's Hospital.

The symposium was inaugurated by Professor Cyril Chantler who greeted our guests and expressed his excitement about this first initial Anglo-French rheumatology venture. In his reply Professor Bernard Delcambre, Chief of Rheumatology at CHRU, was equally enthusiastic about this initial meeting and hoped that this might pave the way to future collaboration between the two centres in clinical and scientific rheumatological research. Professor Grahame chaired the conference with presentations from both units.

The topics of discussion on the day included:

- *Measurement of metacarpal in osteoporosis and cimentoplasty in bone tumours* Prof B Duquesnoy
- *Screening for osteopenia using DXA* Dr P Ryan
- *Microfocal radiography in the management of Rheumatoid Arthritis* Dr C Buckland-Wright, Dr I Chikanza and Prof R Grahame
- *Scintigraphy using amyloid P protein in haemodialysis arthropathy* Prof B Duquesnoy
- *Biopsy of minor salivary glands, in particular vasculitis in rheumatoid arthritis* Dr R-M Flipo
- *Cysteine protease in rheumatoid arthritis* Dr R-M Flipo
- *Anti-CD4 therapy* Dr E Choy and Prof G S Panayi
- *Cyclosporin in rheumatoid arthritis refractory to classical therapies, comparing with methotrexate* Dr R-M Flipo
- *Overview of T-cell therapy* Dr G Kingsley
- *Anti-phospholipid syndrome* Dr G Hughes

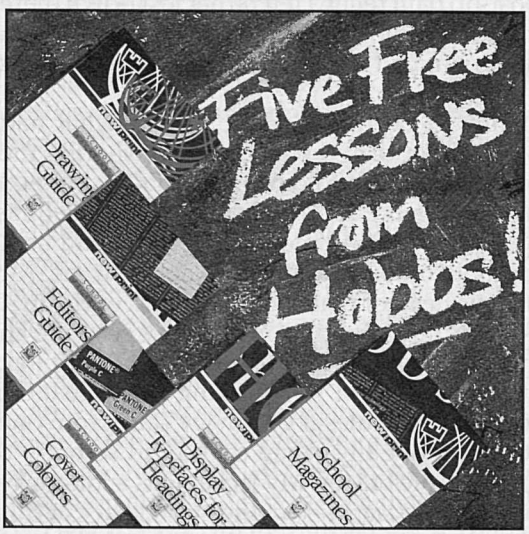
The diversity and range of topics covered exemplified the large variety of research undertaken at both centres. In many instances different approaches were adopted to address similar questions. The shared interest in these fields

was shown by the discussion generated after each presentation. It was clear from the enthusiastic discussion afterwards that there was much to be gained from either centre's expertise and experience both in clinical and laboratory research. Informal exchanges during lunch and tea offered deeper and more detailed discussion in various topics.

This initial meeting lasted only eight hours but hopefully it has set the foundation for a long and fruitful partnership. Special thanks to Miss Jane Williams who helped organize the whole event.

Ernest Choy
Lecturer in Rheumatology

SCHOOL MAGAZINES



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Locums, MB BS and House Jobs

Who gets which one—the riddle remains

When I got home on Valentine's Day, 1970, I was just full of my new-found experience and my poor parents were regaled with the kind of exploits they must have been indulging in for 35 years. Armed with all the confidence of inexperience, I sallied forth for Torbay Hospital, Devon, some two weeks later for a six day locum HS job with Mr Hugh Guerrier. Torbay was under reconstruction at the time and I noted almost immediately that the patients were rather more dour than those in London and tended to need less post-op pain relief. I felt rather lost down there and any confidence I had acquired quickly evaporated. Quite early on, a patient with a ruptured aortic aneurysm died in the ambulance as it made its way to casualty.

His wife, who had been following in her car, had to be told what had happened. The nurses turned to me to perform the grim task of sharing the bad news. I watched her crumple before me as I told her what had happened and I too found it so traumatic that I could have done with a spot of counselling myself in the aftermath. The Guy's training stood me in good stead and held me up but it was then that my irritable bowel made itself known to me. Mr Guerrier was a fatherly man with a fine head of white hair and dark eyebrows. I only met him in theatres and on a couple of ward rounds but he gave me an inkling of what was expected from a surgery chief at a district general hospital. The doctor's mess down there had a rule about not wearing white coats at mealtimes. As it was one of those unwritten rules, I got an icy stare from one besuited consultant and was told to remove my white coat. I did so only to reveal a revoltingly coloured pair of purple braces. My jacket was a long way away in my room so I munched away at the *plat du jour* and stared back at this man; smiling uncertainly from time to time.

Undaunted by my experience in the West Country I applied for a further locum and went as an HS for two weeks at Putney Hospital with Mr Guy Blackburn. Their theatres were under reconstruction at the time so there was little, if any, surgery going on there at the time so I wandered round the

hospital greeting everyone I saw and doing the occasional impersonation of Mr Blackburn. Little did I know just how useful this would be for I would be the one to 'do' him in the Residents' Play in 1971, a year later. The porters in that hospital were a fund of information and had many tales to tell of the late Grant Massie, one of the greatest teachers of surgery ever. The ground must have trembled under his feet wherever he went. Mind you, it was a bit like that with Guy Blackburn.

The locum included the boat race weekend and I was the casualty officer. Only one case came in; a young man had fallen off his bar stool and hit his head on a bar-billiards table. I felt a bit cheated. At other times, though, there were children who had lodged strange things in unusual places. There was the child with some pencil lead lodged slap against the tympanic membrane and another child had an old-fashioned multi-sided threepenny bit stuck at the level of the epiglottis. Guy's was in the Hospitals' Rugby Cup Final that year and I was taken to the match by Mr Blackburn. Prior to our arrival, he stood me lunch in a local restaurant and ordered the meal for both of us. I remember eating an entire grilled kidney.

When we took our seats at Richmond I felt very much on the opposite side of the tracks as the students pelted us with bags of dental plaster in the time-honoured manner. We had a very fine Number Eight in the form of John Forbes who had undergone an appendicectomy only 15 days before he took part in the match. As far as I know, he suffered no ill-effects.

The nurses at Putney were extremely friendly and I had the misfortune to be locked in the Nurses' Home, and had to be rescued by the Night Porter and his keys. Though I protested my innocence with regard to any misdemeanour, I was told to tell it to the Marines and the episode was forgotten. The MB BS finals were looming large and once I was finished at Putney, I set to some serious swotting; swimming and doing a small amount of work every day. The written papers took place on Thursday 16 and Friday 17 April, with the obs and gobs and surgery the following Monday. Most nights during these exams Ed Townsend, Adrian Caro, Peter Evans and myself drank well after hours at the 'Bird-in-Hand', Gravel Road, near Farnborough Hospital; staying until 1am regardless of the exams that followed. The vivas and clinicals were held soon after and it was then that Mr Blackburn sent for me to do a further two week HS locum for him at Guy's. I registered a mild protest that it would conflict with the testing times ahead, but he said it would be no problem and so it was that I came to be taking the MB BS finals and working at Guy's at the same time. How I passed is now but a blur, what with the demands of the job, the hours spent in the Residents' Bar, and those endless trips to other hospitals.

Things people say

Patients say the strangest things to me—and each other. Currently, I am working with a lady who is a grand and glorious mixture of anorexia, bulimia, and obsessive-compulsive disorder. She has resisted every attempt to help her to such an extent that her boyfriend found himself saying to her: 'To save you wasting an appointment with James, can't I go in your place?'

Even though possessed of a persona like a nuclear fall-out shelter, she felt bound to comment that he had been a little insensitive. Better still, though, was the classic heart-sink case who rang me in quite a state because her left ankle had become swollen.

'Shall I come and see you, doctor? Or should I go and have a proper check-up with an ECG and that?'

My reply went thus: 'When you know what you do want, you'd better ring me up for an appointment.'

She came that afternoon.

During my MB BS vivas and clinicals I had an encounter with Mr Michael Brundell at King's College Hospital. I had just examined a somewhat gravid lady.

'Why is this lady here?' he asked me from the other side of the desk.

'Because she's pregnant, sir,' I answered brightly.

He endowed me with one of his saddest smiles: 'This *is* an obstetrics unit, you know.'

I returned his smile and the viva went quite well after that. The clinical at the Whittington Hospital did not go so well; the lady in question took one look at me and refused to allow me to examine her. The gynaecologist was very apologetic and I was taken into a small room and asked a lot of questions about cephalo-pelvic disproportion. Medicine and surgery happened at Queens Square, of course—or they did at that time—and then it was back on with the old white coat and up to New Guy's House for more of the same. The pass lists were posted at Senate House, the first and only time I ever went there. I had my degree sent through the post.

I still attended the Mortuary most lunch-times. Colin Hunter-Craig was a natural teacher and possessed a booming voice. One day he asked that most fateful of questions: 'Why has this patient been brought to me?'

'Because he's dead,' replied an anonymous voice from the back. We all laughed, of course, but maybe we shouldn't have. There are many ways of stating the obvious.

'What shall I tell my family then?'

'Tell them you've had an exacerbation,' I reply.

'What's that?'

'Well—it's a worsening of whatever it is you've already got.'

'And what's that?'

'Well—to find that out we have to extrapolate backwards in time to the last time you felt quite well—and just before you began to fell ill,' I reason.

'That was the time when we began to make a diagnosis and since then it's been up and down form you've been exhibiting—like Tower Bridge.'

Time off for bad behaviour

During 1969-70 there were several things that happened to me. One of these was an invitation to sit as student representative on the South Eastern Faculty of the Royal College of General Practitioners. It was at Princes Gate that I met my old school doctor, Dr E J C Kendall MD(Cantab) MRCP FRCGP. He'd gained his MD(Cantab) in 1963 although the nub of his thesis for this illustrious doctorate was never clear to me. All I remember is that 550 boys at Epsom College had their throats swabbed and their urine collected in mid-stream for the purposes of research. I suspect that he was making the connection between bugs in the throat and protein in the wee. I was summoned to appear before him at the Sanatorium. They had found some protein in my water and the news came like manna from heaven to the honest-to-goodness skiver in me. There followed ten glorious days of indolence in the San. The School San (as it was called) was the most modern an best equipped—but that was when it was built—in 1933. Such symptoms as I could muster usually appeared the day before we had to play soldiers in the Combined Cadet Force (CCF). It was my custom to limp in a determined manner to the San on a Friday morning having acquired the necessary chit from my housemaster the night before. I have no idea why I spent so much time in the San with my albuminuria, but, once there, the handful of us who'd made it were determined to stay for as long as possible. After lights out, we'd get exercising as hard as possible on the grounds that absolute bed rest had been made mandatory. What that did for poor Dr Kendall's results we neither knew nor cared. Once it was dark, one could leg it out of the lower windows of the San and get some beer from the local off-licence, but we had to break bounds to do it. Happily, we were never caught. So it was that we got time off for bad behaviour and Kendall got his MD(Cantab).

As already indicated, I never enjoyed my 'army' career as a student. It was always on a Friday afternoon. There was fish for lunch, either steamed or with some revolting cheese sauce adherent, and that was invariably followed by semolina with a dollop of strawberry jam—or a dreadful rice pudding.

As I'd starred in the Army Proficiency Exam by coming first in two of the disciplines, drill and orienteering, and done the compulsory Corps Camp at Lowestoft, I should have got my stripe and maybe two more, but such was my anarchy in matters military that I only ever stuck at lance-jack. On night-exercises on Ashdown Forest I always brought my section in first due to an ability with map references and compass. Even so, I never made it to sergeant. At the time of writing there are three Old Empsomians holding the rank of Captain in the Royal Navy (Messers Morrison, Lane and Henderson) and the Cadet RSM of my day (Lindsay) got the Sword of Honour at Sandhurst.

During the Iranian seige at Princes Gate there was a mischievous part of me that secretly hoped the SAS might chuck one of their very loud squibs through the 'wrong' window. In the event, as we all know, they got it 'right'; Kate Adie cut her teeth for the BBC, and the Coroner who eventually covered the winding-up proceedings was one Dr Paul Knapman, Barrister-at-Law, and late of Wilson House, Epsom College. Strange to think that one of the boys who fagged for me would one day be Secretary of the Scottish BMA—Dr A J Vallance-Owen. Now he moves steadily upwards whilst Dr Lee-Potter is already at the top of the pile. He, too, went to Epsom.

I sat on the RCGP for some 18 months whilst I heard the early plans for vocational training of GPs being discussed. The RCGP had the right idea though, built as it was on foundations housing some of the finest toilet facilities in London. As I've heard many a builder say since, one should always drain the land well first before doing anything else. I did learn that doctors make very good politicians and in argument they were an awesome crowd with the one rather evident proviso: that if ten geniuses sit down to a discussion they can become something of a hydrocephalus; whereas nine numbskulls can make a clever man fell like a fool. There is no answer to this and it is one reason why the top chess players limit the time taken for each others moves—and rightly so. A result is inevitable.

The Guy's rebuilding program was well in hand in 1969-70 and the Tower was some five storeys high when I first joined the house there. I sat on a committee which heard the needs for the student hostel and remember participating in a discussion as to the numbers of loos and bathrooms there should be on each floor.

House job allocations—how little has changed!

I applied for a house job at Guy's. The procedure whereby these posts were filled seemed obscure, and try as we might, it was very hard to find out just how the allocations were passed round the successful applicants. It was already evident that certain people at Guy's in non-medical posts had a large

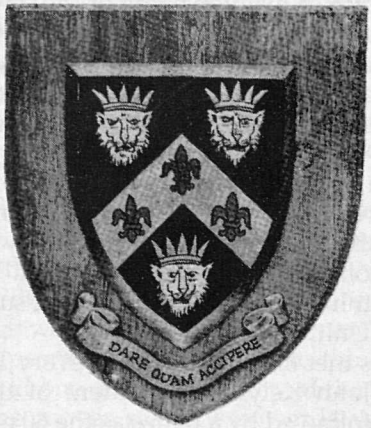
amount of executive power—or maybe we imagined they did. (So what else has changed!—Ed). I applied to work for Mr Rex Lawrie, Everyone wanted to be his houseman in spite of his nick-name of the day: 'Smiling Death'. This was attributed to his ability to tear strips off dressers whilst maintaining an eveness of temperament where lesser men may have blown off their tops. However, one house officer got a chance to do a second pre-registration job and he, too, had chosen Mr Lawrie—which was how I came to be HS to Professor Sir Hedley Atkins—my second choice.

I felt baffled by such procedures but was very happy to have landed a plum job which involved three months at Guy's and three months down at the New Cross Hospital with Mr John Hayward at the newly built Breast Unit. I was the first HS to be appointed to that particular post. I was also appointed to work for Mr Ivor Broomhead who had eight plastic surgery beds there known as the Plastic Surgery Unit.

The Guy's Residents met for a buffet lunch every Tuesday and on my first occasion we elected John Kelynack President of the Residents. Then the Secretary was chosen followed by a pause as the 60 of us considered the post of Treasurer. It was Ruth Seifert who said: 'What about James Pitt-Payne?' (Ruth is now a distinguished psychiatrist at St Bart's Hospital). The suggestion appeared to cause universal merriment and I was elected *nem con*. When I came to examine the Bar accounts, I could see why. I had inherited a financial disaster in the making and they had chosen the wrong man for the job as my knowledge of business was lamentable.

J H Pitt-Payne

Guy's Hospital Gazette



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Rheumatology

Colour Guide: Rheumatology. J M H Moll. Published by Churchill Livingstone. Price £7.95

This book has provided not only an essential on-the-clinic reference for the student, doctor or other health care persons, but also for students taking final examinations and doctors sitting for the MRCP examinations.

In general, rheumatology is a speciality eminently suited to pictorial representation with alterations in the morphology of the limbs and trunk combining to form a myriad of unique clinical patterns, which once seen are rarely forgotten. This colour guide is well written with superb high quality colour clinical photographs. The text is concise and gives brief details about the conditions in the pictures. This format is very well suited to examination revision. As this book covers a wide range of rheumatological conditions I would recommend it for use by medical students, hospital doctors, and general practitioners would find it particularly valuable.

I Chikanza
Senior Registrar in Rheumatology

Clinical Examination in Rheumatology. M Doherty and J Doherty. Published by Wolfe. Price £12.50

Illustrations can undoubtedly illuminate difficult concepts and present information in a way which aids understanding and memory. This book is full of illustrations, all hand drawn.

The introduction deals with basic anatomy relevant to the locomotor system, biomechanic concepts and terminology. The second chapter presents a brief history and examination screening procedure to pick up rheumatologic problems in defined areas. I found this book invaluable, as an exhaustive history and examination for all conceivable rheumatological conditions is time consuming and often unnecessary. Subsequent chapters deal with the examination of the different major areas of the locomotor system in an easily understandable and digestible manner. where appropriate, reference is made by way of illustration to relevant anatomy. I found the book very easy to read and follow. The use of extensive illustrations and clear instructions on methodology enables one to apply basic anatomy in order to recognise common and important causes of regional locomotor symptoms.

I can thoroughly recommend this book to all doctors and medical students.

I Chikanza
Senior Registrar in Rheumatology

Dental handbook

Oxford Handbook of Clinical Dentistry. Laura Mitchell and David Mitchell. Published by Oxford University Press. Price £14.95

The design of this book (as part of the Oxford Clinical Series) is clever in that it will conveniently fit into the pocket of a white coat.

Inside, the layout, with many blank pages on the right hand side, gives space according to the preface for 'the reader to add his own comments and updates'.

One is left wondering however, if this is in reality for the reader to supplement or even correct some of the printed material. A large amount of information is

crammed into a small book and the authors are to be congratulated on this, however the use of vast numbers of abbreviations can be confusing and slows the rate at which the book can be read.

Factually, parts may be questioned by some authorities, but dentistry is a clinical science, and perhaps in a text designed to give an overview this is not surprising. Warning must be given however to undergraduates who may form the erroneous opinion that there are no shades of grey between black or white.

In summary, a useful pocket book that needs to be used in conjunction with (rather than instead of) standard texts, but which allows its readers scope for instant amendment without defacing the text.

P N Sheppard
Senior Clinical Lecturer
in Oral and Maxillofacial Surgery

Neurology texts

There are now a plethora of textbooks on neurology available and most follow the same encyclopedic format, with accounts of the aetiology, pathology,clinical features, diagnosis and management of neurological disease. Most set books have sections on the neurological examinations and diagnostic principles. Such books can only be evaluated against the requirements of their intended readers.

Medical students need full accounts of the commoner neurological conditions, but not the rarities. MRCP candidates, registrars and general practioners need a wider coverage with more on management. Neurologists need more specialised texts and may use the large multivolumed textbooks to determine a particular point, but usually prefer to consult original papers. It is with these points in mind that I have reviewed some of the smaller textbooks currently available:

Brain and Bannister's Clinical Neurology 7th edition. Revised by Sir Roger Bannister. Published by Oxford Medical Publications. Price Hardback £50, Paperback £22.50

This well known book has been extensively revised and unfortunately the result is a little patchy. For example, plasma exchange in myasthenia gravis is mentioned in a section on the general principles of treatment, but not mentioned at all in the section on myasthenia gravis, and there is no mention of occular myasthenia.

For a book published in 1992 it is surprising to find no mention of vigabatrin, lamotrigine or clobazam in the chapter on eplipsey, and few physicians would still think that phenytoin is the first drug of choice for epilepsy, Valproate is not given in a list of the more commonly used antiepileptic drugs. Sumatriptan is not mentioned in the management of migraine.

Although it is well written and easy to read, I did not find it easy to extract particular items of information quickly from text. The illustrations are of better quality than most books and there is a good index.

It is probably too large a textbook for most students and there is insufficient guidance on management for most physicians who would probably prefer Lord Walton's revision of Lord Brain's other major textbook, *Disease of the Nervous System.*

Essentials of Neurology 6th edition. Lord Walton. Publilshed by Churchill Livingstone. Price £18.50

This well established textbook was recently reviwed by Professor Hughes in the *Gazette*, and I agree with his conculsion that it is probably the best undergraduate textbook on neurology. MRCP candidates will also find it satisfactory for most of their needs.

The Little Black Book on Neurology 2nd edition. J S Bonner and J J Bonner. Published by Mosby. Price £11.50

This diminutive book was designed to fit into a houseman's pocket. The topics are arranged alphabetically, presumably for ease of reference. There is a mass of facts and detail, without much guide as to their relative importance. Some busy house physicians might find it useful for quick reference, but it is not suitable either for medical students or MRCP candidates.

Neurology—a concise clinical text. M Swash and M S Schwartz. Publilshed by Bailliere Tindall. Price £14.95

These authors have choosen a problem-orientated format so that reference to a particular point requires extensive use of the index, which is just about up to the job. The text is quite concise but easy to read and packed with information, probably too much presented in too compact a style to be particularly suitable for medical students, but it can certainely be recommended for MRCP candidates, very good value.

Student Notes—Neurology. C N Martyn. Published by Churchill Livingstone. Price £9.95

It is difficult to know quite what this book was intending to achieve. The first 108 pages deal with examination in a curious order, motor, sensory, and then cranial nerves and finally higher fuction. This is followed by 33 pages on neurological investigations, leaving only 133pages for description of diseases, which are subsquently so brief as to be inadequate. Not recommended.

Neurological Skills—a guide to examination and management in neurology. M J G Harrison. Published by Butterworth. Price £18.90

This short book is divided into three sections, the first on the history and examination, the second on common problems in neurology, and the last 25 pages on a number of neurological conditions. Students will learna great deal from reading this book, which is full of good clinical advice and is well worth reading the first two sections. Unfortunately it is not possible to cover neurological conditions in 25 pages with anything like an acceptable degree of detail. Recommended as an adjunct, but not a substitute for a standard textbook of Neurology.

Neurology and Psychiatry. P N Plowman. Published by Wiley. Price £11.95

This cartoon guide to neurology and pyscharity is simplistic and inadequate, not recommended.

Neurology and Neurosurgery Illustrated 3rd edition. K W Lindsay, I Bone and R Callander. Published by Churchill Livingstone. Price £24.95

This book relies heavily on its numerous illustrations, around which a brief succinct text is set out with extensive use of sub-headings and different typefaces

which breaks the text into short statements. Not particularly recommended for medical students though some students will find the format attractive. A good book to have on the ward for students and nurses to browse.

Aids to the Examination of the Peripheral Nrevous System. The Guarantors of Brain. Published by Baillere Tindall.

This little book should need no introduction, it is a must for medical students, physiotherapists and doctors, including consultant neurologists; but I am biased.

Of these nine books, Walton's *Essentials of Neurology* is probably the best single buy, Swash and Scharwtz's *A concise clinical text* is a good buy for Membership candidates and excellent value. Harrison's *Neurological Skills* can be recommended as additional reading for students and junior doctors.

M D O'Brien
Physician for Nervous Diseases

Wartime dentist

Dentist at War. Edward L Moll. Price £9.50

The author of this small book, Edward L.Moll, entered Guy's Hospital as a Dental and Medical student qualifying in Dentistry in 1934 and as a Doctor in 1938.

The preface informs us that his family suggested he wrote a history of his army career. Dr Moll was commissioned in 1940 as a Lieutenant (later Captain) in the Army Dental Corps and in his book he describes his postings to various countries during the second world war.

In a lucid and readable style, he recalls the people he met and the conditions endured in the various quarters and barracks he occupied throughout the war until he was discharged in 1946.

He describes the voyages to Sierra Leone, to Western Desert thence to Cyprus and Palestine and finally Europe for the last stages of the war. Although the title suggests otherwise, there are, in fact, few references to the extent or variety of dentistry required of the Dental Corps during wartime nor any mention of participation in the management of maxillo facial injuries.

Although enlisted in the Dental Corps, possession of a medical qualification allowed him to be allocated orderly officer's duties and given charge of an ambulance post. He graphically recounts his experiences in the Western Desert close to the front line with the Field Ambulance where he did little dentistry and was mainly involved in the treatment of casualties.

This book comprises ten chapters and being just over 100 pages long is so full of amusing anecdotes and interesting diversions that it can be read in one sitting.

There are a few diagrams and black and white photographs and the volume is published by the author himself in the hard back form.

This is the most enjoyable read and although priced at £9.50 (including postage) every book sold ensures that £2 is donated to the Ex-Services Mental Welfare Society.

P M O'Driscoll
Consultant Oral and
Maxillo-facial Surgeon

Guy's Hospital Gazette

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Dr F H Brain

Dr F H Brain died peacefully at his home in Sevenoaks during the early evening of Saturday, 12 September, 1992, aged 84 years.

Frederick Howard Brain was born in Abbey Wood (then in Kent), on 4 May 1908. The following year the family moved to Loughborough, where the father, Frederick Joseph was appointed Secretary (later, Director) of Wm Moss and Sons, a firm of builders and contractors. Howard, as he was usually known to his friends, was an intelligent child and went to Loughborough Grammar School at the early age of 10. Five years later in 1923, when only just over 15, he passed the School Certificate (Oxford Board) with eight credits and one distinction (in Chemistry).

Two years of sixth form studies culminated in the Higher School Certificate, with a pass in Mathematics and distinctions in both Physics and Chemistry. With such an academic record, it is perhaps not surprising that Howard won a Major Open Scholarship to Jesus College, Cambridge which he took up in October 1926, after leaving school in July of that year.

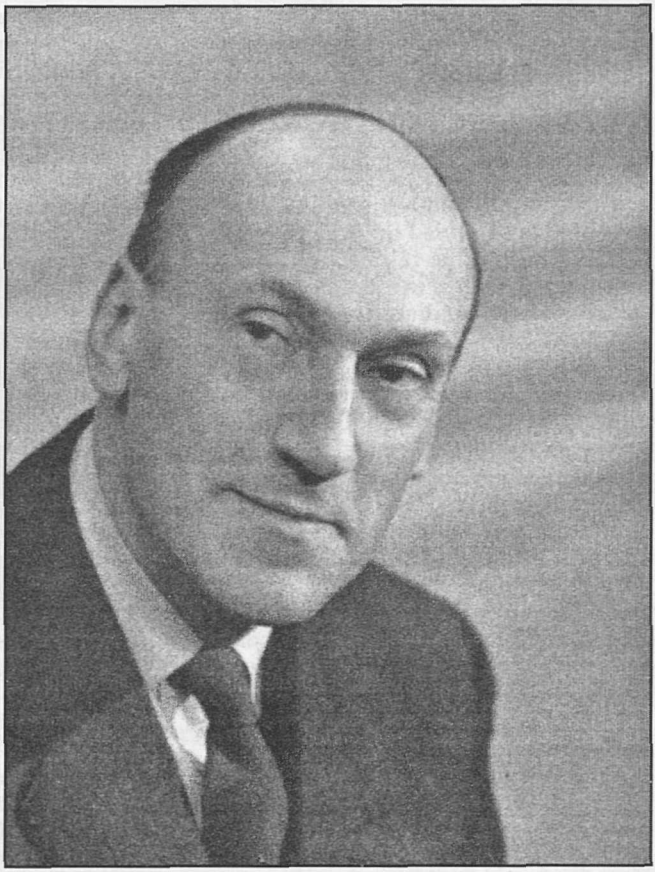
Howard's University career proved to be as distinguished as his secondary education, as he gained First Class Honours in both Parts of the Cambridge Natural Sciences Tripos, as well as taking a First in the BSc (General) of London University, in Chemistry, Physics and Mathematics.

In October 1929, Howard started a three-year research project under the direction of W H Mills and supported financially by a grant from the Department of Scientific and Industrial Research (DSIR), a Sommerville Exhibition and a Goldsmith Senior Research Studentship. This work resulted in a PhD thesis, entitled *Dissymetric Oxonium Salts* (1933) but, along the way, he had also been admitted to the MA degree (January 1932).

Dr Brain's University teaching career began with his appointment in October 1933, as Demonstrator in Chemistry under Professor C S Gibson, Head of the Department of Chemistry at Guy's Hospital Medical School at that time. Subsequently he was promoted to Assistant Lecturer, Lecturer and finally to Senior Lecturer in Chemistry, his duties Including the teaching of Chemistry to 1st MB and LDS students, as well as the more advanced chemistry of biologically-important compounds to 2nd MB students. As seniority increased, almost inevitably he took on more responsibilities for running and organizing lecture and practical courses, not only for medical and dental students, but also for clinical dental students (the chemistry of photography) at Guy's.

Howard was also extremely active in the sphere of A-level examining for both the Cambridge and London University's Schools Examining Boards and was, at one time, Chairman of Examiners in Chemistry for the latter. I remember, also, that he organized and marked A-level practical examinations in the Departmental laboratories at Guy's, with the help of Dr I G Anderson.

His early research in the department, done in collaboration with Professor Gibson and ICI, was concerned with the chemistry of gold compounds and this resulted in the publication of some papers and a British patent. Later on, he collaborated with Dr Helliwell (Head of Department of Anaesthetics at that time)



in a clinically-important project involving the estimation of trichloroethylene in air and in blood.

September 1939 saw the start of World War Two and the School was evacuated to Tunbridge Wells. It was at this time that Dr Brain first met Professor G A D Haslewood, who later was to become Head of the Departrment of Chemistry and Biochemistry (as it became known). As well as continuing his teaching and administrative duties, Dr Brain was appointed Gas Officer to Tunbridge Wells Battalion Home Guard and later, Deputy Senior Advisor to Dr J Kenyon and then to Professor Gibson in Region XII.

It was during the wartime period (1941) that he married Irene Griessen, and his two sons Peter and Michael were born in 1942 and 1945, respectively.

With regard to 'extra-mural' activities, as he called them, Dr Brain admitted that, 'he was no good whatever at sport,' playing only 'indifferent' tennis. He loved classical music, played chess, went on caravanning holidays, liked 'mending things' and, in his own words, 'messing about the house'. In addition, and perhaps typical of his desire to help people, he was Secretary to the Cambridge University Boys' Club. In his early years at Guy's, he lived at the Cambridge University Settlement in Camberwell, where the Club met. He helped with the social activities of the Settlement, including the Boys' Club and Poor Man's Lawyer, and was later appointed to the Settlement Council, eventually running the Club until 1939 when evacuation of the Medical School took place to Tunbridge Wells.

I first met Dr Brain when I was appointed Assistant Lecturer in Biochemistry at Guy's Medical School in January 1960. He was already a very senior figure in the Department and I learnt and enormous amount about academic life and lecturing techniques by talking to him and listening to him lecturing. I still remember how I envied the way in which he took the trouble to explain difficult concepts to students in a simple way. He always showed kindness to his students and never seemed too busy to give up time to help them, whether they were in need of academic or pastoral help. He was a quiet man who was devoted to his family and self-effacing about his own academic achievements. He also had a delightful sense of humour which surfaced from time to time. He was certainly a University Teacher of the highest calibre and, when he retired in 1975, it was a great loss to the Department. He will be long remembered with great affection by his friends, colleagues and generations of past students alike.

He leaves a widow, Irene, and his two sons, Peter and Michael, and it is to them and the other members of his family that we extend our sincere sympathy at this time.

D B Gower
Emeritus Professor of
Steroid Biochemistry
London Hospital Medical College

Professor Haslewood writes...

I came to know Howard Brain in 1939 when the Preclinical Departments were evacuated to Tunbridge Wells. He was a Lecturer in the (then) Chemistry Department, responsible chiefly for the teaching of organic chemistry, which continued when the Department became that of Biochemistry and Chemistry after the war.

Generations of Guy's men and women will remember him as a kind, sympathetic and extremely talented teacher who always had time to talk to students in difficulty. His lectures were lucid and he tried to make a subject which is unpalatable to medical students as clear as possible. Organic chemistry is not now in the syllabus as such but in those days a lot of material was taught which we would now think superfluous. Dr Brain had no difficulty in accepting a diminution of his subject and readily adapted to it. He also kept records on every student in the Department and had a shrewd idea of their ability and character. In his research he was scrupulous about accuracy and impatient of any kind of sloppy work.

He was a delightful colleague with a keen sense of humour and deserves to be remembered as an outstanding teacher of science in our Medical School.

Professor GAD Haslewood

Guy's Hospital Gazette

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News from 'Facilities Management'

In the September issue we reported the appointment to Guy's of a Director of Facilities Management.

What is Facilities Management all about—and why do we need it?

The purpose of a hospital is obviously clinical care. But to make that happen there needs to be a good back-up service—in catering and cleaning, portering and estates, laundry and sterile services etc. In many ways a hospital is a large hotel. Our patients will judge us as much by our ability to get these things right as by our clinical services. We are also conscious that time spent by clinical staff in getting the 'hotel' right is time which detracts from their real purpose in life.

We haven't always got it right in the past. 'Who do I contact for this' 'which requisition pad do I use for that?' 'Well, how long is it going to take?'—how often have you all asked these questions. And yet staff in all the service departments want to do their best but are often equally bemused or hamstrung by the constraints within which they have to operate.

Facilities Management pulls together all the support service departments into one cohesive whole. There are three main sections:

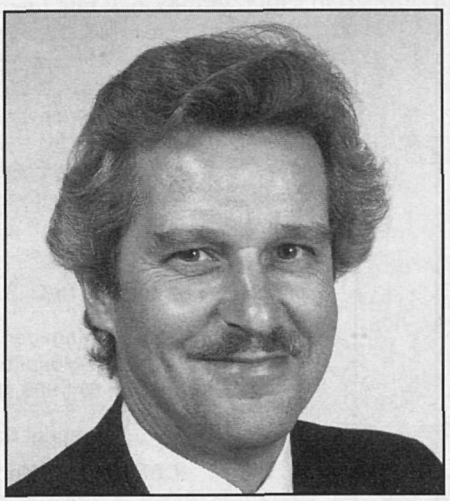
- Works—the operational maintenance and control of the hospital's buildings and engineering service's;
- Projects—new developments, particularly Philip Harris House;
- Hotel and commercial services—controlling domestics, portering, catering security, residential accommodation, private patients, overseas contracts, hygiene, health and safety, pest control and commercial ventures (such as A Piece of Cake).

In addition the new Director will have responsibility for on-site control of laundry and sterile products. The main aim is to get rid of the present artificial 'divides' between departments and offer a more streamlined and responsible service to users.

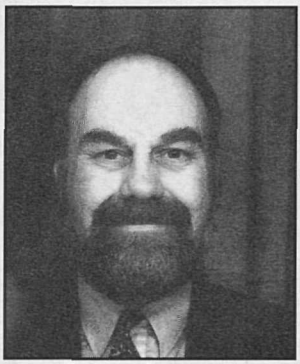
It will take us time to get into top gear. But it is our intention to improve and to make the life of the clinical staff easier.

The *Gazette* has kindly agreed to offer us a regular slot so that we can tell you what we are doing and, importantly, get comments from you. These are the mug-shots of the managers. Over the next three months we will address each section in turn and in more detail. In the meantime feel free to stop us at any time and give us your views. Watch this space.

Sandra Carnell



Graham Perry
Director of Facilities Management



Robert Simpson
Director of Works

Sandra Carnall
Director of Projects

Lee Soden
Director of Commercial Services

Professor Poswillo's retirement

An academic celebration on his retirement

Following the style set in 1991 with the retirement of Professors A H R Rowe and M N Naylor, an academic celebration was held on 14 September to mark the retirement of Professor D E Poswillo.

The first speaker was Professor Hermann Sailer from the Department of Oral and Maxillofacial Surgery at the University of Zurich. He recounted the times that he spent at the Royal College of Surgeons research centre at Downe, Kent working with Professors Poswillo and Cohen, perfecting the use of lyophilised bone and cartilage in reconstructive procedures.

Next, Mr J D W Barnard, consultant Oral and Maxillofacial Surgeon at Queen Alexandra's Hospital, Cosham gave an account of how he had been encouraged to research the effect of cryoblockade in trigeminal neuralgia by Professor Poswillo. Initially this work was carried out at Queen Victoria Hospital, East Grinstead and subsequently at Oxford.

Professor and Mrs Poswillo with Mr E G Smith at the reception.
(**Photo:** Mr V Rajayogeswaren)

The third speaker was Professor J P Sheppard, University College of Wales, Cardiff. He had first met Professor Poswillo when a house surgeon at Queen Victoria Hospital. Impressed by the professor's encyclopedic knowledge, he was disappointed that nothing was known about the effect of the cryoprobe on the dental pulp. His first research project was therefore under way.

The final speaker was Emeritus Professor B Cohen, then Director of the Department of Dental Science during Professor Poswillo's time at the Royal College of Surgeons. He told of Professor Poswillo's early days of research in his garden shed in New Zealand, where his interest in teratology was born studying cleft lip and palate in rats. This work continued with the effect of teratogens including the blighted potato about which Poswillo soon became an authority. His work in this field was also used to great effect in unravelling the devastating effect of Thalidomide in the early 1960s. Reference was made to Professor Poswillo's broad and international career which included consultant oral surgery posts in the UK as well as in Australia and New Zealand, work with the Department of Health, the World Health Organization, the Medical Defence Union and his appointment as Professor of Teratology at the Royal College of Surgeons.

Following the formal presentations which were masterminded and chaired by Mr P D Robinson, a reception was held at which Professor F P Ashley, Dean of

the Dental School at UMDS, presented Professor Poswillo with a landscape scene of a typical riverside in rural England by Fraser, himself the grandson of a surgeon.

Among the many guests at the reception were Professor M Downer, Mr C Howard, Prof A H R Rowe, Sir Paul Bramley, Mr B Mouatt, Mr E G Smith, Mr G Fordyce, Mr R Bret Day and many other past and present colleagues and friends.

Paul Sheppard
Senior Clinical Lecturer in Oral and Maxillo-facial Surgery

Confidentially

I wonder how many readers can recall the author and singer of the song, which sold a million records, and which is my title this month? But 'confidentially' is not always the manner in which some nurses behave.

A friend of mine was recently admitted to another hospital. At admission for cold surgery, he was requested to take himself, and a form to the X-ray department. This form was contained in one of those familiar unsealed transit envelopes, which have multiple spaces for addresses. Now that we live, since last November, in an era of freedom of information insofar as patients have access to their records, my friend thought it would not be amiss for him to have a peep at the form during the inevitable wait at the X-ray department.

On opening the envelope my friend was surprised to find not only a request form for his own X-ray, but another for a rather more elderly patient—judging by the date of birth. He was interested to discover the diagnosis on both these request forms, and also to note that whilst the box labelled 'walking' was ticked in his own case, the one marked 'chair' was ticked on the additional form.

Later, on returning to his ward, my friend pointed out that there had been a mistake—that two different forms were contained in the open envelope. Imagine my friends surprise when he was told that this was not an error, but a routine way of speedily transmitting additional X-ray requests for patients who needed the services of an X-ray porter to transport them from the ward.

While readers gasp at this laps of confidentiality, I am sure no one will need reminding of Clause 10 in the UKCC Code of Professional Conduct for Nurses, Midwives and Health Visitors: *Protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by the order of a court or where you can justify disclosure in the wider public interest.*

No, this clause was not designed to anticipate the lapse I have described.

Whilst it is perfectly permissible now for patients to read details about themselves, this surely does not mean they are free to read about other patients? Possibly no harm may come, as most in-patients are only too ready to talk to each other about their ailments. But, then it is *their* wish—what they may not want, is for other patients to know their date of birth and address. Indeed, a fertile imagination can invent a situation where unscrupulous patients may note the address, the time the spouse of an elderly patient visits the hospital, and inform a 'friend' that the coast would now be clear for a spot of burglary!

I suggested to my friend that he takes the matter further, by way of a formal complaint, as a clear breach of confidentiality had occurred. But no, he did not want to cause trouble. How many patients fall into this category I wonder? At Guy's we now have *Let Us Know* forms which can identify problems anonymously—but obviously a specific complaint may readily identify the sender. Indeed, judging from the completion of these forms which I have seen, few patients are prepared to write anything untoward about the nursing and medical care. Maybe this is really what they think, or are they, along with their gifts of sweets and chocolates, too much in awe of their carers to lodge disapproval? When pointing this out, my friend said, did I think these gifts were a form of bribery? If I did, then, he said, I was going too far! The UKCC Code of Practice has also been elaborated on in an advisory paper. The main theme of this is that all confidential information is given in 'trust'. To trust another person with private and personal information about yourself is a significant matter.

I suppose years of working in the Lloyd Clinic, where confidentiality means that no-one else, even in the hospital, let alone another patient, gets to know either the presence of a particular individual or the clinical details of our patients. It was a byword in wartime that 'careless talk cost lives', just as it could be if written information falls into the wrong hands.

The UKCC advice is concerned with weightier situations than the one I have described. It asserts: *determining the difficult boundary that applies in any case between the expectations of patients and information, whether recorded or not, obtained in the course of professional practice will not be discussed, and the expectations of the public that they will not be put at risk because practitioners withhold information unreasonably.*

And what is the answer? The UKCC is not altogether helpful in that it *is not seeking to provide responses to those dilemmas since a judgement must be made by the individual practitioner concerned. It is instead seeking to provide guidance on disclosure of information.*

Some guidance is offered thus, but the final judgement is: *Each registered nurse, midwife and health visitor is accountable for his or her practice.*

In some instances there may be good reason for the deliberate breach of confidentiality in the public interest of a patient. I hardly think, nor I am sure would readers, that the speedier passage of a document, via another patient, instead of by a member of staff, would qualify as a 'good reason'.

The UKCC's view is summed up thus: *That a patient has a right to expect that information given in confidence will be used only for the purpose for which it was given and will not be released to others without their consent,*

and *that practitioners recognize the fundamental right of their patients to have information about them held in secure and private storage.*

Incidentally, *Confidentially* was sung and written by Reg Dixon a few decades ago.

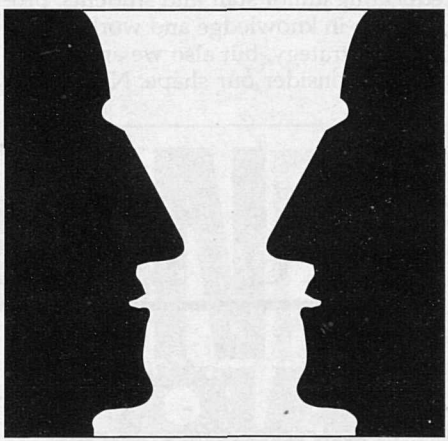
Denis Cobell

Profiles and re-profiling

Surely everyone is familiar with the profile which depicts either two people facing one another or a candlestick. When one looks at one profile one cannot see the other and vice-versa.

The Victorian excelled in painting portraits of people in silhouette. Many a drawing room is enhanced with families silhouetted on the walls. Generally these are painted in black on a white ground or are paper cutouts in what today we may describe as a monochrome collage. The original work invented by Etiennede Silhouette in 1759 was produced in cutout form. We also observe an object, which is set against bright light, in silhouette or in profile.

In recent years there has occurred a managerial connotation of the terms; moving from human, geographic or structural terms to that of description of more nebulus forms. Each organisation has its profile which describes the hierarchy, aims, objects and processes. A more immediate process is that of re-profiling.



Everyone is, or will be (before someone else does it for them) pressured into self-analysis and subsequent moulding of the defined facts into another shape.

Re-profiling carries that in-built statement of change, it seems not to allow for any possibility that the structure under review is in prime form. Recognising the fallibility of man this is probable; but will the new image be better—or merely different.

The therapy directorate has taken the bull by the horn and started its own reprofiling exercise with the help of an experienced outside facilitator. It is likely to be as full of hazards as was the gymnastic vault of Vaour performed by the youths in ancient Crete. Hopefully we will survive and succeed in the task, maintaining our service to the patients the while.

Life in the NHS has become even more of a juggling feat, not only are we assessing, treating, advising and managing rehabilitation programs for the patient and their carers, writing appropriate records, educating junior staff and students, progressing in knowledge and working to a quality strategy, but also we are finding time to consider our shape. No wonder we dream of 56 hour days and the delights of the 24 hour days of yore.

What the physiotherapist and OTs will find in Pandora's box is yet a mystery. If all else fails hope should remain. If we do not find a new profile we will certainly have a better understanding of each other and of ourselves and from that deeper knowledge will grow the therapy services of the future.

I hope that we will find all components of the picture. People facing each other and communicating with each other in the light shining from the candle which we find is supported by the candlestick. Maybe we will even further push out the restraining perimeter.

Diana Innocenti

GAZETTE SPORT

Sports directory

Perhaps after the festivities of fresher's week you might actually want to remember what you achieved and maybe try to find out what happened to that 50 quid that you gave to the UMDS ..... club? With this in mind, Phil and I have decided to compile a sports directory so that you may directly annoy any captain or secretary that you may wish to. We've also added a list of phone numbers to make this a little easier.

Badminton Club
Ajay Gautama 081-858 4119 (Rm C7)

Basketball Club
Parjam Zolfaghari 081-458 8812

Diving Club
Simon Thompson 081-809 1648

Football Club
Men's
James Hollinshead (I) 071-820 1808
Ladies'
Sarah Brooks 071-385 1076

Golf Club
Ed Hughes 071-326 0870

Guy's Boat Club
Men's
Jonathan Robin
(Boland House pigeon holes 1st floor)
Ladies
Louise Ward (as above)

Hockey Club
Men's
Guy Barwell (II) 071-701 3203
Jim Miller (III) 081-690 5957
Ladies
Juliet Marshall (I) 071-582 8351
Sujata Dave (II) 071-737 3027

Martial Arts Club
Ajay Gautama 081-858 4119 (Rm C7)

Mountaineering Club
Richard Guinness 081-692 3592

Netball Club
Nicola McDonald (I) 071-237 5784
Sally Sheffield (II) 071-231 4613

Rifle Club
Chris Davies 071-738 8053

Rugby Club
Guy's
Simon Russell (III) 071-237 3935
Marc Blunden (IV) 071-274 0119
UMDS
Richard Breeze (I) 071-326 0870

Running Club
Simon Fearby 071-820 1806

Skiing Club
Mark Lewis 081-692 3592

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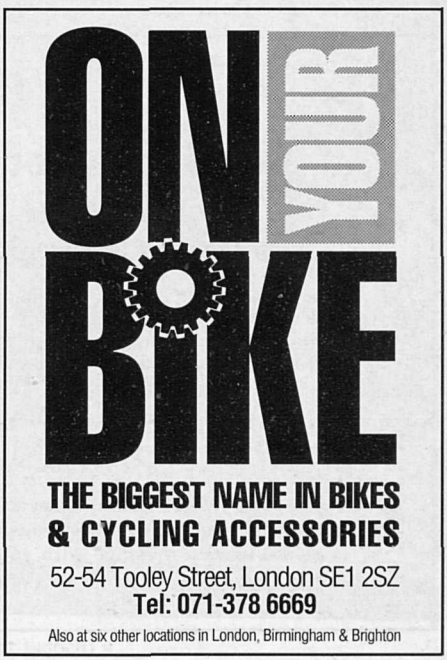
Victor Peant 071-252 0862

Windsurfing Club
Roger Lightfoot 081-692 3592

Abhi Lall and Phil Marino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Deaths

HILLIAM, Ivor Hobson LDS, RCS, died on 9 October 1992. Aged 69. A dearly loved husband. Father and grandfather. A service of thanksgiving for his life was held at Poole Crematorium on 15 October.

TAYLOR, Basil, qualified Guy's 1940, died 25 September 1992. A memorial service was held at St Dunstan's, Mayfield. He leaves behind his wife, daughter and two grandchildren.

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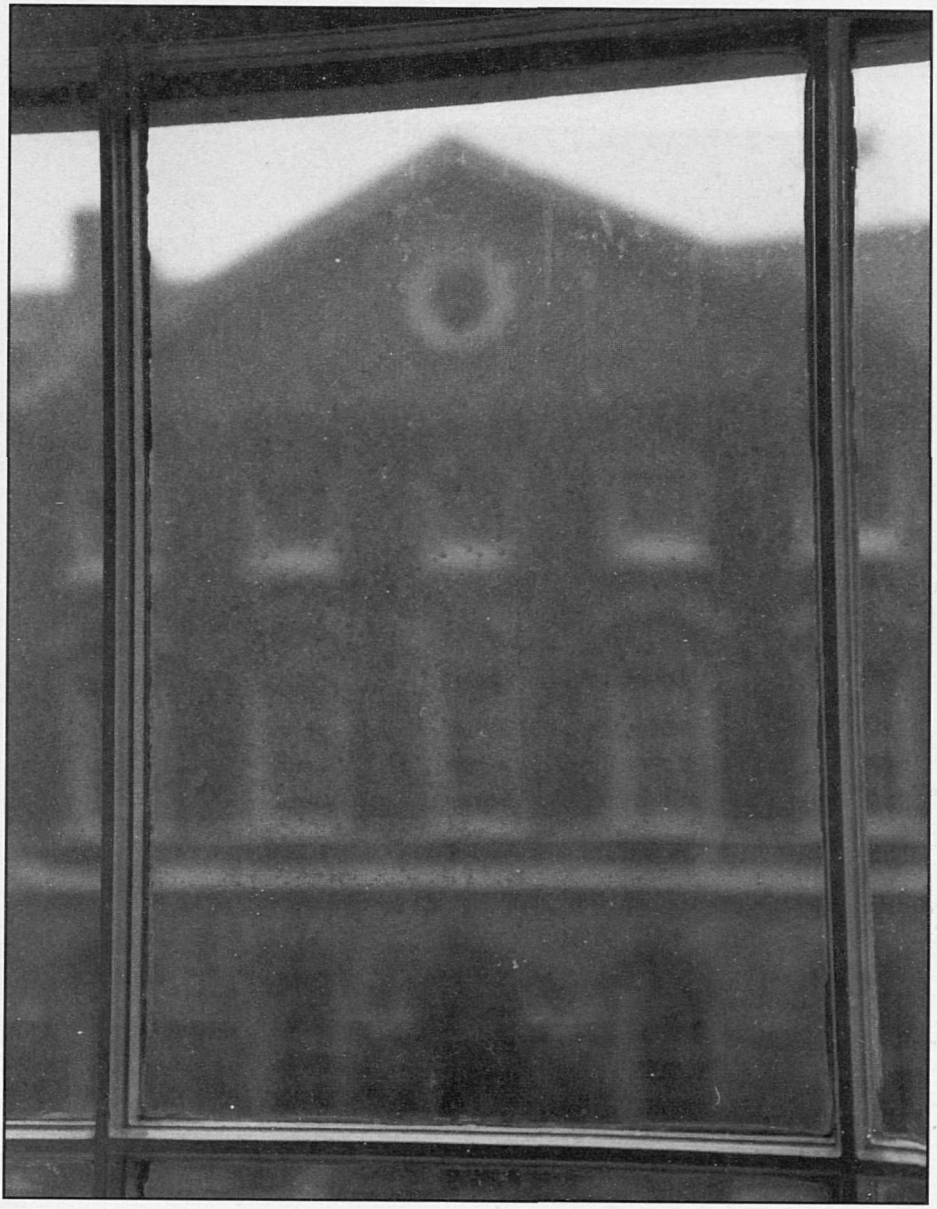

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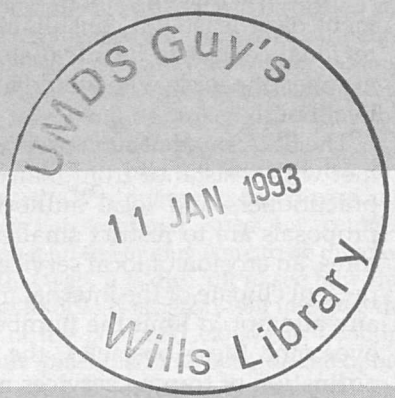

Guy's Gazette

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The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

The British Orthopaedic Association (BOA) has only just published a report following a three year survey into the treatment of skeletal trauma victims in the UK. Their results confirm a belief held by many orthopaedic surgeons that the concentration of trauma care into specialized centres will give rise to a higher standard of treatment. Their survey suggests that as many as 12% of patients could have been treated more successfully, preventing severe disability and loss of function if the treatment of severe skeletal trauma was restricted to such designated centres. The recommendations are that there should be approximately one in each of the regions, catering for a population of between 200,000 and 500,000.

Although meeting the recommendations would involve the appointment of at least 100 consultant orthopaedic surgeons to enable these regional centres to be adequately staffed, this is offset by the reduced number of people who would lose their functional ability and thus their livelihood.

The BOA say that such proposals as they are recommending are often met with resistance from many sources, including the public, general practitioners and local authorities. There is a feeling that since the proposals are to restrict smaller hospitals to treating only minor fractures, an erosion of local services will be occurring. Furthermore, in the present climate of the internal market, some hospitals will try and resist any attempt to limit the number of types of patients that they see. To overcome these obstacles, the BOA suggests that some form of co-ordination of trauma services needs to take place.

On a different note, as many readers will know, the next issue of the *Gazette* is in February. By that time perhaps more definite information may be available regarding the future of London's hospitals. On the other hand, perhaps we still won't know for sure. In the meantime though, let me on behalf of everyone at the *Gazette* offer you the season's greetings, and very best wishes for the New Year.

St Thomas Guy's Hospital?

Dear Sir,
If and when Guy's is forced to merge with St Thomas's Hospital may I suggest that the new institution so formed is named St Thomas Guy's Hospital.

Yours faithfully,

B H BASS
PO Box 66
Los Gioantes
Tenerife
Canary Islands

Great minds think alike

Dear Sir,
If Guy's and St Thomas's *must* merge, and a new name has to be found for the combined hospitals, why not solve the problem by beatifying *our* own revered founder and calling the place St Thomas Guy's? This would surely satisfy everyone at each establishment.

Yours faithfully,

HUGH M BAIRD
Greenhead
Balmaclellan
Castle Douglas
Kirkcudbrightshire
DG7 3QJ

Tomlinson fury

Dear Sir,
I am incensed at the proposals of the Tomlinson report to merge Guy's and St Thomas's on one site, with the consequent destruction of one of these great hospitals.

It is absolute folly to close any of the great centres of medical excellence in London. If procedures do cost more in these centres, surely it is a price that everyone should be willing to pay. Most people in this country and world-wide have come to regard them as international centres of repute and hope for patients; once destroyed they can never be replaced. Thousands of patients will be denied advanced medical and surgical treatments, for which many are very willing to travel great distances; vital research and teaching teams will be broken up, with incalculable consequences.

All this to provide 'cheaper but improved' GP community based care and fewer 'streamlined' specialist centres. Even if all the money were to be directed in this way, it is difficult to see how this cosy middle class ideal will improve the lot of the poor and elderly in London. Many practices have been updated, but the need is for beds. Pressure on bed space in London is already great. As quoted recently in the *Daily Telegraph* by Myles Harris, a London GP, statistics from the Emergency Bed Service (EBS) show that 'refereed cases' ie cases where the EBS uses its power to force a hospital to take a patient, possibly meaning the cancellation of a routine admission, rose from 10% to 33% of all admissions between 1987 and 1991. No amount of GP care can replace this need. The Government, led by the missionary like Virginia Bottomley, seems determined to implement these proposals and, as the strong rumour is that Guy's will be the site to close—what are we going to do about it?

I am sure, or at least, I sincerely hope, that much is being done behind the

scenes at Guy's. Equally I am certain, that across the length and breadth of the country and overseas, past and present members of the Guy's staff, Guy's patients and their relatives would wish to stand up and be counted in the fight for the future of Guy's.

Can you give a lead through your columns as to constructive and effective ways that this 'silent' army of Guy's supporters can contribute to the campaign? For my part I would willingly give money, harass MPs, even march. What do you suggest?

Yours faithfully,

ELIZABETH BELL (née Murray)
(Guy's 1958-63)
21 Burrill Road
Bedale
North Yorkshire
DL8 18T

Threatened hospital clubs

Dear Sir,

A side issue to the threatened closure of London teaching hospitals prompts one to wonder what will be the fate of the many United Hospital sports clubs.

The UH rugby cup in the years before the war was a major sporting event and had been right back to the roots of the game.

In those years I derived a great deal of pleasure from the United Hospitals Hare and Hounds Club which was one of the oldest cross country clubs, inaugurated in 1886. (See *Guys Gazette* 2 March 1957).

A trophy, the Kent Hughes cup, was competed for annually and not only Guy's but Bart's, Thomas's, London, King's, Middlesex and Mary's were always involved.

I wonder if this and other inter-hospital clubs have survived and can continue to do so.

Yours faithfully,

D J LYON
Littlefield
Keyworth
Notts

Boat Club—internal wrangles

Dear Sir,

I was very disappointed to read the letter from Messrs Robins and Cash, 'Not the Guy's Boat Club' printed in the October *Gazette*. Whilst I wish to avoid involving your publication any further in the 'internal/infernal' wrangling of the boat clubs. I feel I must represent the so-called 'dormant' UMDS/St Thomas's Boat Club on a few matters arising from the letter.

St Thomas's and Guy's Boat Club was registered with the Amateur Rowing Association (ARA) four years ago to enable combined crews to row at Henley Royal Regatta. Last year all members of St Thomas's voted at their AGM to row under the name of the combined club wherever possible, namely the ARA and national events. This was the closest step to an 'amalgamated' club we could achieve last year, yet we were unable to row under the combined name in all inter-hospital events. This is a situation which has, thankfully, recently changed.

In the last year, 30 freshers were recruited to row for St Thomas's and Guy's.

Men's and Ladies' novice squads were formed who rowed throughout the year until the Bumps. I am therefore unaware of losing any 'freshers overboard without a trace'.

In response to the accusation that our 'last two hospital trained oarsmen were ordered to walk the plank just before Henley', the two gentlemen involved insist that I stress that this was a situation of which they were fully aware and were happy to accept as 10th and 11th oarsmen. I am sure this was the case with most 'changing' crews prior to Henley.

Lastly I wish to point out that the reason for St Thomas's 'failing to make a single men's competition entry between Christmas and the Bumps' was due to the fact that we were busy training for and racing in events at Leicester, Cambridge, Newhaven and Bedford. We also experienced a touch of coastal rowing, racing at Portsmouth and Southampton, on a highly successful boat club tour.

We have always worked hard for an amalgamated Boat Club and, more importantly, for our aim to represent both campuses when we row. The names of both hospitals have been taken nationwide from coast to championship, and we shall continue to do so.

I would like to think that one day soon the two boat clubs will unite under the name of UMDS. This is the only way forward from the stagnant standards of rowing consistently achieved by UMDS oarsmen and women.

Yours faithfully,

TIM BATES
Captain (1991-92)
St Thomas's Hospital Boat Club
St Thomas's Campus
London

Boat Club schoolboys

Dear Sir,
I can stir just enough energy to pen this letter.

I am fed up with reading and hearing constantly about 'the boat clubs'. Foolishly I thought that I had left little schoolboys behind when I left primary school.

Is now not the time for the boat clubs to sit down and talk to each other instead of this humiliating public mud slinging. It is the spirit of neither Guy's nor St Thomas's to carry on in this way.

More importantly, Freshers should not have to be made pawns in a dispute that makes the Commons look civilised.

Yours faithfully,

A WARD
Student President
St Thomas's Campus
Lambeth Palace Road
London

Inappropriate labelling

Dear Sir,
To say I was outraged at the inscriptions put on people's hands at the Rugby Club hop on 6 November would be an understatement. It appears that people were initialed, and labelled, depending on their sex and racial origin (thus 'WF' stood for White Female, 'PFT' for Paki Female Tramp etc).

If people such as those who were writing these inscriptions have not yet learned, after several years at medical school, that human beings really are equal regardless of their sex and degree

of pigmentation, might I suggest they turn to vocations other than medicine and dentistry in which tolerance and humanity have no importance.

Yours faithfully,

SHAHID KHAN
Boland House
Guy's Campus

Hopping mad

Dear Sir,

I would like to express my disgust and anger at the attitudes adopted and displayed by certain members at the Rugby Club Hop on 6 November. On entering, the code imprinted on my hand was PFT. If I told you that WFT stood for white female tramp, one doesn't need a very high IQ to guess what P stands for. I would like to remind these members that the majority of Asians at UMDS are not from Pakistan, and consider it a racist slur to be referred to as a 'Paki'. Are these really the tolerant caring medics of the future?

Yours faithfully,

SMITA PATEL
Boland House
Guy's Campus

Biennial Dinner

Dear Sir,

May I, through your columns, thank very sincerely all those who attended the recent Guy's Hospital Biennial Dinner and helped to make it an enjoyable evening. Can I also take this opportunity of pointing out that the next Biennial Dinner will be held on Friday, 7 October 1994 at the same venue and perhaps this date could be put provisionally in your diaries for that occasion.

With best wishes.

Yours faithfully,

MARTIN JOURDAN
Department of Surgery
Guy's Hospital

Progenitor hospitals?

Dear Sir,

The following is an extract from a letter in the *Times* dated 28 October, from a St Thomas's obstetrician in relation to the Tomlinson report: 'Not all doctors are up in arms at the Tomlinson report. I welcome the proposal that Guy's once again merges with its progenitor hospital.'

The *Oxford English Dictionary* defines the word progenitor as an ancestor of person, animal or plant, political or intellectual predecessor or the origin of a copy. I wonder what Thomas Guy would think?

Yours faithfully,

W B D MAILE
Prinstead Grange
Prinstead
Emsworth
Hants
PO10 8HT

Patient Centred Care

This new concept in hospital management featured in the *Gazette* of July 1992 is to be implemented at Hillingdon Hospital, a north west London Trust. Andersen Consulting the pioneers of Patient Centred Care, have formed a team with staff from the hospital to draw up the details for a pilot patient centred area within the hospital. It is hoped that the pilot project will be running within a year.

Andersen Consulting, the world's largest business and technology consultants, came up with the Patient Centred Care approach by studying the developments that have been taking place in the organisation structures in other industries. The results of a survey of 10 NHS hospitals were published earlier this year which highlight inefficiencies in the provision of health care in hospitals. Hillingdon hospital was one of those which participated in the survey.

It is claimed that Patient Centred Care will overcome the problems identified and improve the quality of patient care and also increase staff morale and job satisfaction.

Postgraduate research student adviser

Dr Malcolm Segal has been appointed to act as an adviser for postgraduate students preparing for MPhil and PhD degrees. His role will include advising students having health, financial or accommodation and other such difficulties; establishing an association for postgraduate students at UMDS; and providing independent advice to postgraduate students in their final year of supervision. Postgraduate students can contact Dr Segal via the Division of Physiology on the St Thomas's campus.

More about Tomlinson

London hospitals await the Government's decision of the implementation of Sir Bernard Tomlinson's recent report. A decision to follow the report's recommendations would lead to the diversion of resources from the hospital sector into primary and community health care services; a change in the delivery of primary care is also suggested, for example the location of GPs in accident and emergency departments.

The report suggests that the requirement for inpatient beds in the inner London hospitals will fall, and proposes a reduction of about 2,500 beds in the acute sector. There is a recommendation that: 'a single management structure for Guy's and St Thomas's should be created, with the specific task of rationalising services onto the chosen site. It should complete this work within two years.' A division in the Guy's and Lewisham Trust is recommended.

With respect to medical education and research, Tomlinson recommends merging eight London medical schools into four 'under the aegis of the four multi-faculty colleges of the London University'. In the case of UMDS this would involve a merger with King's College School of Medicine and Dentistry, and an association with King's College. There may also be increased undergraduate

teaching in the community and peripheral hospitals, and a reduction in medical student intake of about 150.

Annual dinner

The South Wales Guy's Hospital Society will be holding its annual dinner at the Park Hotel, Cardiff on Saturday 6 February 1993 at 7.30pm. Tickets are priced at £20. All Guy's men and women are invited to attend with friends. Doctors, dental surgeons, nurses, physiotherapists etc are all welcome.

This is the night of the rugby international between Wales and England at Cardiff Arms Park.

Further information can be obtained from Graham Davies, 23 Windsor Road, Radyr, Cardiff, CF4 8BQ, Tel (0222) 842479.

Rugby Club—150th anniversary

The foundation of the club in 1843 is accepted by both the Rugby Football Union and the Guinness Book of Records. While no contemporary documentation has survived, abundant circumstantial evidence, including a fixture card from 1883-84 referring to Guy's 40th season and the submissions of distinguished officials in 1863 and 1864, confirms the date.

In the early days, the club played on Blackheath Common and after the formation of Blackheath RFC in 1858, shared with them from 1862 a dressing room in the Princess of Wales hotel. At that time the rules were decided before each game by the captains. As a founder member of the Rugby Union in 1871, Guy's contributed to the basic structure of the game as it is now played.

From 1920-30, Guy's fielded the most formidable team in the land and the reputation achieved in that decade lingers to this day. The club has created 34 international players, the first in 1872, the last in 1970, and has won the United Hospitals Challenge Cup 30 times.

The club currently runs five sides and competes in the RFU London League Division 3 South West, and is currently the highest placed of the London hospitals. Despite not attracting the day to day press attention of erstwhile years, the name of Guy's is synonymous with hospital rugby and retains its lustre.

Celebratory events

- **Sunday 17 October 1993**

Festival day of rugby at Honour Oak Park
Public School Wanderers v Guy's President XV
Guy's XV v United Hospitals
Guy's Oldies XV v Blackheath Veterans
Guy's Ladies XV v University of London

- **Sunday 28 November 1993**

Guy's XV v Rugby School XV
Traditional 1843 kit will be worn

- **Friday 29 April 1994**

150th anniversary dinner at Waldorf Hotel

- **1-20 July 1994**

Guy's RFC tour to South Africa

Guys Hospital United Clubs Union Shop
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CLOSED ON WEDNESDAYS

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Professor Cyril Chantler

An interview with the recently appointed Principal

From August 1, Professor Cyril Chantler has been the new Principal of UMDS. Recently I went to speak to him to find out what his plans were and how UMDS plans to consolidate and improve its position in these changing times.

Professor Chantler came to Guy's in 1960 from Cambridge. By the time he qualified, he had already decided to pursue a career in paediatrics, and took the opportunity to do a paediatrics house job. He joined the staff at Guy's in 1972 and later became Professor of Paediatric Nephrology.

I asked him first of all about the achievements of UMDS in these past 10 years. He was keen to stress that the new institution had been a great success. The unified basic science departments have been of importance in providing the right environment for undergraduate, postgraduate teaching and research. In addition, he points to the increasing uptake of BSc courses amongst students, now including dental students, as a positive step. UMDS has also been conducting a fundamental review of the medical and dental curricula which are being implemented at present.

There was concern about the poor research rating that UMDS received two years ago, but Professor Chantler is awaiting the new rating with interest. He believes that considerable improvements have been made since. These are reflected in increases in the number of students studying for higher degrees, and a very encouraging increase in grant income from all sources from £10.9 million to £17.6 million.

But, have these changes been uniformly welcomed by the staff and student population? Professor Chantler's reaction was realistic. People are always a little bit anxious about change, he said, at least as a first reaction. However, in today's rapidly changing world he believes that change should be looked upon by all as something that is to be expected and constant. It should also be something that is welcomed since it implies an ability to keep up with the new developments. He hopes that the negotiations about the amalgamation with King's will be greeted positively by everyone. Professor Chantler hopes that the results of UMDS will show for themselves that the changes that have taken place have been for the best. 'Life must have been easier for my predecessors,' he muses, since they had the benefit of living in a relatively stable period of

time.

Professor Chantler's appointment as Principal is for five years, extendible by another two. I asked him what he hoped to see happen during that time. Top on his list was a desire to see the school rugby team win the Hospital's Cup once again. That aside, he would like to see UMDS be renowned for excellence in all areas; art, music, sport, academic and research achievements. UMDS should create an atmosphere which allows its members to excel, yet not feel pressurized in so doing.

Professor Chantler was very unhappy about the Finals results. He viewed it in part as a failure of UMDS, which although it can't physically learn for its students, should provide an adequate opportunity to do so. It is the responsibility of the school, not so much to teach, as to ensure that there is the correct environment and stimulus to learn.

A disproportionate number of students who failed were from the last exclusively St Thomas's year. I was curious to know whether any reason for this had been identified. Although it is difficult to hypothesize on the basis of one year's set of results, an inquiry is still being carried out. Characteristics about the courses and the individuals concerned are being investigated, but no conclusions have yet been drawn. One of the themes that seems to be present though, is that those students who have trouble during Finals, have often had problems with earlier parts of the course.

Professor Chantler also questions the appropriateness of the nature of the Finals. He sees the new clinical curriculum, starting in April 1993, as the way forward. Pathology will then be examined in the first clinical year, paediatrics and obstetrics and gynaecology in the second clinical year, and a final exam covering the principles and practice of medicine and surgery. The final clinical year should also be more relevant to the responsibilities of a pre-registration house officer than at present. This new course, with some continuous assessment should ensure that anyone who has done a reasonable amount of work should be well prepared for Finals. It is also hoped to be able to offer locum assistantships to final year students in the jobs which they will be starting on qualification, in order that they may be well prepared for life as a house officer.

Continuous assessment is bound to bring up the subject of sign-ups. I am sure that a book entitled *Everything you always wanted to know about sign-ups but were afraid to ask* would span several volumes. The first question that Professor Chantler felt was important to consider was whether the system was necessary. Given that we all live in a competitive world, and that not everyone will be able to get the job they want, he thinks it a fair proposal that those who perform the best should have more chance of getting their choices.

The next point raised was whether the present sign-up system is an appropriate means of continuous assessment. The current method has evolved from the old Guy's and St Thomas's systems, and tries to combine the best elements of each. He accepts that some of the criticisms that were made of sign-ups when he was a student may still be valid, but on the other hand he does believe that improvements have been made. More people have been encouraged to participate in the assessment, including nursing and junior medical staff, in an attempt to assess the 'good citizenship' of students. There is also an opportunity now to discuss the assessment with the consultants concerned.

A perennial concern of students is the discrepancy of grading that different firms award. We are always told that the medical school has implemented a means of normalizing these grades. Professor Chantler confirmed that this is indeed the case, but was unable to elaborate on the mechanics of the process since he is not directly involved. He suggested contacting Dr Rees for further information, but some early reports from SMEC seem to indicate that Dr Rees is not directly involved either.

There is another role of assessment at the end of a firm that Professor Chantler wanted to promote; that of auditing teaching. While it would be inappropriate for students to grade individual consultants, he thought that firms as a whole should be encouraged to feed back information regarding their teaching and its success at meeting the objectives set.

The planned changes to the curriculum extend to the addition of a new course—the MB PhD programme. UMDS is currently seeking ways of introducing this scheme, (something similar is offered at Cambridge), but is being held up by the present regulations of the University of London which stipulate that students may not be registered for more than one degree simultaneously. Nevertheless, guidelines for a MB PhD programme are being drawn up, and Professor Chantler is hopeful that the barriers that exist are soon to be rescinded. Although he accepts that this course may not be something that very many students take up, he knows of some who are already keen to embark on the combined course, and looks forward to it as an exciting development.

I suggested to Professor Chantler that the positive changes in the curriculum regarding a systems based approach and the greater integration with clinical studies at an earlier stage might be jeopardised in the process of merger with King's. One of the proposed benefits of a merger with King's is the creation of a multi-faculty life-sciences based campus that can help to broaden the experience of medical students. However, I put it to Professor Chantler that a disadvantage would be the separation from other health care specialities, such as nursing, radiography and physiotherapy. He was adamant though that this would not be allowed to happen. UMDS was committed to the fundamental changes that were taking place in the curriculum, and these were broadly in line with contemporary thoughts on medical education. He was pleased to note that UMDS has had the foresight to introduce these changes before being forced to. He also stressed that students are being consulted about the King's merger through the offices of the Clubs' President.

At the time of the interview, the Tomlinson report was soon to be published, but Professor Chantler was in a confident mood regarding the strength and ability of UMDS to cope with any proposed changes. The actual recommendations regarding Guy's and St Thomas's were much as expected, and the position of UMDS had been made clear beforehand; that rationalization of specialities should take place with one site being developed for mainly hospital use along with clinical science and teaching, whilst the other was developed for university purposes but with hospital facilities also, particularly for the local population. Space thus freed, could be used to house the academic departments, possibly of a combined institution with King's. It was also accepted that in the much longer term, it may be necessary for one or other site to close. What will actually happen remains to be seen.

FFH

Guy's First Medical Superintendent

The centenary of the death of Dr John Charles Steele

Last month, 6 November 1992 to be precise, marked the centenary of the death of one of the most remarkable members of the staff of Guy's, whose great contributions to the Hospital are often forgotten. Dr Steele gave nearly 40 years of dedicated service to the Hospital, initiated the modernisation of nursing and in his unceasing efforts to bring order out of disorder, left a uniquely detailed account of day-to-day events in Guy's during the important transitional period in medicine of the second half of the 19th century.

When the novel post of Medical Superintendent was advertised, the Governors were unanimous in selecting from among 97 applicants, Dr Steele, who was then the Superintendent of Glasgow Royal Infirmary. As a precaution, Bonamy Dobree the Treasurer had travelled to Glasgow to make on the spot enquiries, but the wisdom of their choice was fully vindicated in the ensuing years.

Dr Steele was duly appointed in 1853 and gave the rest of his life to Guy's. He devoted his efforts to ensure that every penny of the hospital's income should be well spent, that the standard of nursing should be raised, that the nurses' working and living conditions should be ameliorated and that all the staff's and even the students' complaints should be dealt with. Apparently trifling examples of his attention to detail are that he checked the prices of the eight different types of coal burnt in the hospital and even the number of loaves produced from each batch of flour to ensure that there was no pilfering.

His task was not easy and inevitably, students were a frequent source of trouble. In 1866 for instance Dr Steele was forced out of bed at 5.30am by the noise from the dressers' room where he found a veritable riot in progress and that several windows in the Colonnade and Surgery had been smashed. As usual, the reason for the trouble was the lavish supply of beer available in the dressers' room. As a consequence, noisy parties going on until the small hours, kept the patients and the tired nurses awake, tricks were played on the nightwatchmen and sometimes things got out of hand. On another occasion

glass specimen cases from the Materia Medica museum had been smashed. An old student, Mr Edinboro' [sic] was also so persistent a source of trouble that Dr Steele had forbidden him admission. 'His visits to the Dispensary have of late become a perfect nuisance', but the culminating event had been 'a ridiculous demonstration' he had made while the scripture reader was enlightening the patients. The young women cleaners in Surgery also complained about being 'much annoyed and insulted' by students while they were working, and during a University clinical examination several patients complained of being roughly handled.

But it was not merely Guy's students who were to blame and there was more serious trouble in 1862 when two Bart's students got into Accident Ward during divine service and were alleged by the surgeon Mr Cock to have broken a patient's recently united fractured leg.

Yet, students must have found Dr Steele sympathetic, for they sought his protection when bullying became too much for them. One even complained to him about an unprovoked insult from a fellow student and another protested about 'offensive epithets' that were being continually written about him on the walls of the Demonstration Room. That aside, Dr Steele expressed enlightened views about the organisation of medical teaching which cannot have endeared him to the senior staff.

For nearly 30 years Dr Steele, rather than the Matron, looked after the welfare of the nurses. In so doing, he took care to deal with any indiscipline, insubordination or occasional lapses into drunkenness. In 1857 he proposed to relieve the nurses of the interminable scrubbing of floors by employing cleaners. He also arranged for nurses to be boarded-in so that their time would no longer be wasted by their daily shopping sorties and they would be better fed. They were to have the hospital 'full diet' of meat, bread, butter, potatoes and porter (a heavy dark beer regarded as having tonic properties) but Dr Steele favoured the addition of cheese and milk even though it would bring the cost up to ninepence ($4^1/_2$p) a day. If this seems niggardly, it was appreciably more than paupers on outdoor relief received for a *week's* subsistence at that time. Despite considerable difficulties Dr Steele also managed to provide a dining room 'To render the meal comfortable and beneficial'.

One of his major innovations was that nurses should have leave of absence once a week in the afternoon 'or oftener if thought desirable for purposes of health and recreation'. Dr Steele's next two changes made an even more radical break with the past. The first was that nurses should have a uniform which 'could not fail to be attended with a humanising influence on the inmates'. Until then they had worn their own, none too clean clothes, though some also wore a large bronze medallion to indicate their ward or other special duty.

Despite the cost, the Treasurer Mr Turner praised the provision of full board and indoor uniform which had 'been attended with improvement in the health of the nurses and in the respectability of their appearance'. The next change was revolutionary in that the conscientious Dr Steele began to give the nurses lectures, the first they had ever received. By the 1860s, a newly appointed nurse underwent a period of pupillage and moved about the hospital to wherever additional help was needed. At long last the nurses were having some education and their training became so widely esteemed that probationers from private nursing institutions were sent to Guy's for preliminary instruction. Well before Florence Nightingale's ideas became widely accepted, Dr Steele was looking towards the time when greater numbers of nurses could have comprehensive training in medical and surgical nursing and midwifery, and become permanent members of the hospital staff. Further reform of nursing was demanded by the new Matron, Miss Burt and agreed by the Treasurer Mr Lushington in 1880, but without discussion with the staff. Dr Steele undoubtedly made himself deeply unpopular with the physicians and surgeons by supporting Miss Burt's changes in what became known in the press as 'the great nursing dispute' which left scars for many years.

If the earlier nurses had a reputation for drunkenness, the enormous quantities of drink used in the Hospital must have presented a temptation. Alcohol was so greatly valued as a medicine that barrels of wine and spirits had to be kept. Dr Steele made no criticism of the fact that in a typical year (1859), 1047 *gallons* of port, 265 of sherry, 256 of brandy, 99 of gin and 51 of rum were distributed. Patients absorbed nearly 14,000 pints of porter while sisters and nurses consumed nearly 3000 pints a year as part of their ordinary diet; the Obstetric resident and dressers also had an allowance of two pints of porter a day.

Intriguing information is provided by Dr Steele about the amount and the nature of the surgery and its mortality in his day. Until the mid '70s, there were only six or seven operations a week and in Steele's Report for 1864 for example, there were 314 operations with 62 deaths, but the surgery was 'of a more severe and of a more fatal character than in former years'. Thus of eight ovariotomies there were five deaths and of 9 trephinings, 7 deaths. But even with amputations 15 died after 46 operations.

The aspirations of the surgeons were not dampened by their failure to control infection. Later, three double amputations had all been fatal; eleven ovariotomies had lead to five deaths and the two Caesarian sections had been fatal. Tracheotomy had been successful in four cases but fatal in nine; herniotomy was successful in eleven cases, fatal in three; two attempts at colotomy had been fatal as had been a single case of excision of the spleen. Hardly likely

to lessen infection was Dr Steele's mention of 'a new method of treating an aneurysm by stuffing it with horse hair'. It also proved fatal.

The operating theatre facilities of this period were also remarkably primitive. Dr Steele noted that, 'The fireplace in the Operating Theatre smokes very much every time a fire is placed in it' and in 1857, '... it would certainly be advantageous to have basins and pitchers for the special use of the theatre... The supply of hot and cold water...should be brought by the Bathmen who are in constant attendance during operations. The soiling of the bedclothes could be avoided by the use of Mackintosh Cloth, in which case an old and ordinary blanket could be retained for covering the operating table'. But there is the extraordinary proposal two years later for a '...design for a small electromagnetic machine for surgery purposes...the instrument is frequently required for cases of suspended animation'. In sharp contrast to such novel ideas was the request, 'Application by two of the physicians for some handy form of candle and candlestick for examination of internal passages...'

However, Guy's was the first London hospital to adopt Lister's antiseptic methods. The surgeon Henry Howse was the first to do so and Dr Steele enthusiastically installed antiseptic sprays in the wards several years before Lister was appointed at King's. Thereafter operative mortality started to decline and by the end of Dr Steele's period of office increasing numbers of operations were being carried out with declining mortality as aseptic techniques began to be adopted.

In strong contrast to the operations, the mortality in the Lying-in Charity was surprisingly low. By the middle of the 19th century, it handled over 1700 deliveries a year. Dr Steele's Report of 1858, for example, showed that 1731 women had been delivered of 1748 children. Only two women had died, one from haemorrhage the other from puerperal sepsis. His tabulation of these women's previous confinements provides a remarkable comment on the time. First confinements numbered only 254; in 203 cases it was the seventh to 12th, and in one case it was the 20th.

Among innumerable other matters, Dr Steele had to deal with vermin invading the wards, foul smells caused by faulty plumbing or patients blocking the drains with discarded dressings, the violence of maniacal patients, deaths of patients and nurses from cholera and other infections, and much much else. His notes on every day events in Guy's are in such detail that his reports to the Treasurer fill eight large volumes. By his initiatives and unceasing efforts, Dr Steele became an acknowledged authority on hospital management and was awarded the Howard Prize by the Statistical Society. His achievements can only be appreciated when it is remembered that there were no precedents to guide him, but he made this appointment of such importance

that distinguished physicians and surgeons, previously Deans of the Medical School, became his successors.

Dr Steele died in harness at the age of 71 and an appreciation published in the *Gazette* in 1892 fairly states that 'Never was there a man more conscientious in his duties, which indeed he loved, so that his loss will not only be great to the institution he served but to the public at large. As he was often consulted on questions relating to charitable institutions, his position in this country was absolutely unique, there being, we believe, no such office as his elsewhere'. Moreover he was not a faceless administrator and the crowds of nameless poor whom he had helped and who filled the quadrangles of Guy's at the start of his funeral profession provided a visible tribute to his many kindnesses.

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Follies and Fallacies in Medicine

A talk given by Dr Peter Skrabanek

Dr Skrabanek provided an intriguing and undoubtedly controversial lecture entitled 'Follies and Fallacies in Medicine', to a receptive audience in the Tower Lecture Theatre. His libertarian philosophy was aimed at the moralistic, or should I say, sanctimonious element of the medical profession. To simplify his arguments, he was proposing a non-intervention policy by doctors on matters of moral judgement. Under this bracket he included smoking, drinking, sexual behaviour and eating habits. Since these four human behaviours have a profound influence on the progression, if not the causation, of many diseases, the morality of such acts has traditionally been the domain of doctors.

Dr Skrabanek argues that medical science has been inconsistent in its attempts to prove the causative role of these 'immoral' agents in many diseases. Taking cancer specifically, he cited numerous examples of medial reports either promoting or blaming:

1. the consumption of vegetables eg broccoli
2. exposure to sunlight—this is hypothesized to be a risk factor for skin cancer but has been reported as being protective against colonic cancer
3. sexual behaviour—promiscuity is associated with cervical cancer, but nuns have the same incidence of all cancers as the general population (but note that he did not provide figures for cervical cancer in nuns)

Dr Skrabanek therefore concludes that it is not the realm of medicine to moralise. He does however accept that the causative role of cigarette smoking in lung cancer is beyond doubt, but he does not see this as justification for doctors to support no smoking bars, for example. In short, he does not believe that medicine has a role to play politically or ethically when this means compromising the values of others. His non-paternalistic view of medicine severely restricts its scope to one of non-involvement with patients outside of the hospital or clinic, which is surely at odds with the views held by health care professionals as a whole.

Although much of the lecture was presented in a light-hearted fashion, Dr Skrabanek has raised many serious issues. He described himself as a supporter of preventative medicine, yet advising patients to stop smoking, for example, is such an intricate part of both primary and secondary prevention. He also claimed that medicine should stick to a scientific framework. But what room does this leave for empathy, compassion, and the other human qualities that many would regard as therapeutic? In addition, the placebogenic action of much of medical care, whose efficacy is undoubted, cannot be validated scientifically. That is to say, no specific mode of action can be elucidated.

Needless to say, Dr Skrabanek stirred up hot debate from the audience, but generally defended himself competently. His defensive arguments were based on attempting to set boundaries for medical care. Consider, for example, this argument: poverty is responsible, either directly or indirectly, for a great deal of mental and physical illness. As doctors, we would hope to be able to treat both psychological and somatic symptoms of this illness, but can we deal with its underlying cause? Dr Skrabanek's answer is not only an emphatic no, but also that we have no business to, even if we could. Another argument in his armoury was that medicine sets unattainable standards for health. The WHO definition of health is not the absence of disease, but 'a complete state of mental, physical and social wellbeing'. This argument supports the setting of boundaries for health care and thus a more non-interventionist role for medicine. Finally, Dr Skrabanek reiterated Illich's stance on the danger of producing a society dependent upon doctors, as a consequence of unrealistic expectations for health, with the subsequent risks of iatrogenic illness (ie that induced by well-intentioned actions of the medical profession, such as unnecessary medication).

In summary, Dr Skrabanek advocates an amoral, non-interventionist and scientific approach to medical practice, which aims to dispel some of the myths (as he sees them) surrounding the treatment of patients.

Leaving aside the philosophical and political issues, thanks should go to Dr Skrabanek for providing an entertaining lecture; not without controversy, but all the more stimulating for it.

Shubinder Shergill

Surgery at Guy's in 1970

Dr Pitt-Payne's time as a house surgeon

A friend of mine had his house repossessed this year; one of the many in the south east. Like thousands of others, I suspect, he had found himself billeted with his mother-in-law—an unhappy coincidence for both of them. This dear old lady was not without the wherewithal, possessed as she was of a six-figure unearned income and the conviction she had to be very careful. At the beginning of September she was staring gloomily out of the window at the rustic bird table with its peeling bark and the little house on the top.

'We'll be getting that bird table in for the winter soon. I think we'll put it in the garage.'

'Never mind the bleeding birds then,' observed my friend, 'with winter coming and that.'

'They're not *my* birds,' came the reply, 'they're next-door's birds. You can't argue with logic like that.

Working with Sir Hedley Atkins

Professor Sir Hedley Atkins had been in the wars when I first worked for him. Earlier in the year he had been involved in a road traffic accident and the ambulance had taken him from the taxi involved to another well-known teaching hospital, where his neck was duly X-rayed. The hairline crack in the odontoid peg was missed by them and the Guy's radiologists had the satisfaction of making the diagnosis their colleagues had missed. The result was that he appeared in a most spectacular neck brace, which sported extra ironmongery to keep his chin up and reminded me of one of those 'giraffe' women who wear copper rings around their ever-elongating necks to enhance their beauty. At some stage he had also had the head of his humerus excised for a previous fracture dislocation which had begun to go bad on him.

Professor Hedley had just finished his stint as President of the Royal College of Surgeons and had been made a Knight Commander of the British Empire in 1967 and a KStJ in 1968. I had looked him up in 'Who's Who', and found that he occupied the best part of a column in that august reference book. The nearest I had ever been to him was when standing in the lift in New Guy's

House. Invariably he always got out at the second floor where the Department of Surgery was—and still is I trust—housed.

On 30 December 1970, he would be 65 years old, so that made me his penultimate houseman. Even at that stage a young surgeon called Ian McColl was tipped to become the next Professor. Sir Hedley drew the double Firsts from Oxford and Cambridge to his firm like bees to a honeypot and that provided a daunting prospect for yours truly who was determined to find out as much as he could about the *modus operandi* before the job began. In the event, I received a lot of mis-information from the various and several wags who saw me as a somewhat gullible young lad. If I'd taken their advice I'd have been wearing corduroy trousers, elastic-sided suede shoes, brightly coloured shirts, and bow-ties—when the *haute rigeur* demanded nothing less than the three-piece suiting and the short back and sides. So it was that I presented myself to the great man one fine morning in May 1970 wearing my very best clobber and an application of Brylcreem which would have had the lads at Epsom shoving me head-first down the bogs and pulling the chain.

All this puts me in mind with regard to the business of appointments; not making them, but keeping them—and keeping to time. That doyen of the wonderful world of Jungian Analysis, Andrew Samuels PhD, once told a seminar that to turn up too early indicated anxiety, to be on time indicated an obsessional personality, and to be late suggested a repressive personality. I once spent a very trying hour attempting to explain to my training analyst why I bothered to turn up on time and by the end of the session I was wondering why I'd bothered to turn up at all. It was all very tedious.

On that fine day in May 1970, though, I must have been prompt. What Sir Hedley said to me is lost in the mists of time, but I emerged much as Moses must have done after his encounter with God on Mount Sinai; bathed in a comfortable glow and carrying the necessary inscribed tablets which would get me through the months that lay ahead.

The Department of Surgery was sprawled across the second floor of New Guy's House and housed some extremely helpful secretaries; Mr Max Rendall, senior lecturer, and one Michael Bewick. I found out that I would be second on call for Es Will, House Surgeon to Mr Frank Ellis, and there would be lots of arterial surgery, transplanting of kidneys and a variety of tasks I had not bargained for. Bostock House had gone yellow and there had been quite a few fatalities amongst the medical personnel at Edinburgh and Newcastle from hepatitis. I didn't fancy going yellow one little bit and I consulted Es Will who told me that gamma globulin injections might provide me with some protection, but nothing was certain and the best thing to do would be to wear rubber gloves and watch out for sharp needles. This all provided something of a

dilemma. Should I have the painful injections in the bottom and reside amongst the wise virgins, or should I not bother and stay in the company of the foolish ones? In the event I found a sturdy third year nurse on Astley Cooper and asked her if she would be prepared to give me 5ml of the sticky stuff into each buttock.

'I'm going to hurt you—now!'

They were an unforgettable brace of jabs, and I limped away down the corridor wondering whether I had wounded myself unnecessarily. Three months later I had a 5ml reinforcement and I would be very glad that I did. I did not get the yellow jaundice but plenty of others did and they were out of action for six months. Once a week Dr Merivale came and took blood off us to see if any of us were carrying something called the Australia Antigen. His venesection technique was a one off. 'I'm going to hurt you—now!' he'd say as he plunged a No 1 needle into the ante-cubital vein. This always made me laugh. He was a big man with a great sense of humour and a bewildering selection of whiskers. He was referred to as Dr Hairy-Male in Residents' plays. It was a terrible shock to us all when he was killed outright in a road traffic accident only a short while later. Guy's lost a great character.

Max Rendall endeared himself to me because he insisted on being known as Max right from the word go. This made a pleasant change from the formality that had existed elsewhere. Similarly with Michael Bewick who was universally known as Mick by patients and staff alike. In the pioneering days of kidney transplantation, communication was everything and every case on dialysis awaiting a transplant felt confident in what was happening to them. Bostock House by night was like some latterday wonderland with at least 15 dialysis machines on the go. With the illuminations turned down, the blinking lights of modern technology lit the ward with an eerie glow and put me in mind of the decorations in Regent Street at Christmas.

Professor Stewart Cameron and Dr Chisholm Ogg were a formidable pairing and pushed back the boundaries of knowledge which allowed things to happen. We had Professors S Cohen and J R Batchelor and there were the ladies and gentlemen of the tissue-typing team. They were as devoted a group of men and women as I ever met, and with a sense of vocation unequalled by anyone I had encountered.

As for myself, I found a place in the order of things as operator of the crushed ice machine, a most useful piece of kit when one was Treasurer of the Residents and responsible for the smooth running of the Residents' Bar—even if the financial viability of the project was ever-worsening.

The main problem in those days was the clotted shunt and when I was on call for the transplant team, it was to me that the calls came from far and wide—even Norfolk. These blocked tubes could be a bit of a devil and I wasn't too good at unblocking them because the blood clot would have set solid by the time its owner reached Bostock House. I used to practice saying 'clotted shunt' three times very quickly to see if I'd get it wrong in much the same way as some may try the pheasant plucking routine today.

After half an hour of fruitless fiddling with this and that syringe and sodium citrate, it would become apparent that it was time to book a theatre for a revision of shunt operation. In such matters, Mick Bewick proved tireless and extremely patient. The newspapers showed a lot of interest in the program at Guy's at that time and at weekends when I was on I'd get phone calls asking for information about certain young patients who had provided the media with many a human-interest story. Rejection was a problem, of course, and I remember one small boy who came back for anti-rejection treatment. Whilst I was trying to hear what was being said to me on the phone at the nurses' station, the little blighter was jumping up and down on a pogo stick in the corridor of Astley Cooper and making a generally infernal racket. It was hard to believe that the kidney he'd received was starting to be rejected. The courage and tolerance of these children and the grown-ups was something else.

One minor headache was the task of finding suitable patients for transport to Queen's Square for the Final Fellowship Examinations. Sir Hedley appeared to need a steady supply of such patients and apart from free transport, they got fed and kept in cubicles where they would be questioned, examined, and eventually paid the princely sum of ten bob for their troubles. I never met a patient who didn't enjoy the outing, and it made a change from the dull routine of lying about like a spare dinner. I got most of my cases for these outings from Hunt's House because the cases on the surgical side had already parted company with their lumps and bumps. That was always one of the paradoxes of the job; the fact that the medical wards were stuffed full of surgical cases and the surgical wards were replete with medical ones.

There were frequent trips to Nuffield House to assist Sir Hedley in his private work, and though he received no direct remuneration for this on the grounds of his professorial status, nevertheless he acknowledged my assistance at the end of my time with a handsome cheque to mark the occasions I'd been there. He was always totally fair and completely impartial in his dealing with everyone about him, but it became clear after a few weeks that he was a difficult man to know well. On social occasions he was a model of graciousness to everyone about him, and I remember the time when he introduced several of us who he had taken to dinner at the Royal College of Surgeons to the

current President, who, at that time, was Sir Thomas Holmes Sellors. In a red tail coat, Sir Hedley would have delighted the Guild of Professional Toastmasters, but it was a hallmark of his that everything he undertook was done to the highest possible standard. This was especially so when it came to demonstrating surgery to our American visitors who came over from time to time, and his *pièce de résistance* was the axillary sympathectomy, an operation he had devised which involved going through the axilla, collapsing the lung, and making for the sympathetic nervous plexus which supplied the arm and hand. It was quite a business setting up these patients so that everything went smoothly. He did one abdomino-perineal resection whilst I was with him and his mastery of that occasion was as complete and as sure-footed as it was possible to be.

The senior registrar for the first few weeks was John Bull, and he did everything he could to help me on my way. I was sad to see him go on to pastures new. From then on, it was to Max Rendell I turned with my questions and queries. One day I went into his office; the door was opened and Max was sitting there with some tubes and wires coming out of his mouth. It was evident he had connected the lower end of his oesophagus to a pH meter. I saw the needle move rapidly indicating that the gastric acids were being produced at a high rate of knots. Quick as a flash I said, 'Gosh Max! I had no idea I had that effect on you!' He switched off the meter and talked to me as though nothing had happened but I learnt in the twinkling of an eye the speed at which hydrochloric acid can be produced in response to a change of circumstance.

Trying to get blood out of a stone

From time to time I went to the Medical School for worried consultations with the Hospital Accountant, Mr Cook. Things in the Residents' Bar were reaching a parlous stage and we were sinking into the red at an alarming rate. Try as I might, separating money from certain members of the House was like trying to get blood out of a stone, and it was always the ones who seemed to have the highest bills who were the least keen to pay them. Some of the doctors in question had left the Hospital over a year previously. It was decided that the Residents would hold a monthly party where an admission fee would be charged. Maybe we would recoup some of our losses that way.

I worked away at the accounts but I was not really thick-skinned enough to demand monies other than by the invoice system, and this became a monthly nightmare as the amounts we needed to stay solvent became ever larger. Mr Cook was a senior statesman at Guy's with an old-fashioned pair of horn-rimmed spectacles behind which his bright eyes twinkled as he noted my

concern. I always felt better for seeing him, and although he said very little I was given the impression that all would be well—although how on earth that contingency would come about was not to be made known to me because once I had gone to the Breast and Plastic Surgery Units at New Cross Hospital it was someone else's problem, and I was very happy to hand the books in towards the end of August 1970. The Residents' Bar was shut, of course, as I was to find out in the *Evening Standard*, but happily my name did not appear and nor did anyone else's. By the time I came back again for my HP job the accounts had been set on a sounder footing and someone more sensible had been appointed Treasurer.

I tended to rise at seven in those days and at seven thirty I was partaking of breakfast and was on the wards by eight and writing up the various bloods that needed to be done. After that, there was invariably time for a coffee back at the Spit before the registrar's round and then it was either outpatients, the professor's round, or a teaching occasion. Take in weeks happened one in four and then everything went into overdrive. I always tried to eat whenever I could and rarely missed a meal. We were at the mercy of the bleeps in those days and I'm sure that hasn't changed. They always went off at the most inconvenient times but the switchboard were a very tolerant crowd and probably the fastest in London at that time. The head of switch was one Tarquin Barclay—if that was his name, and I'm sure it was. One does not forget a name like that. They were an extremely friendly crowd of young voices and appeared to have their fingers firmly on the pulse of the hospital residents; knowing who was who and where they might be found. I must say I was grateful for their discretion and whenever I fancied taking a bath at 1 am, for example, I'd ring and tell them so and then I'd get 15 minutes in the proverbial tub for which I was duly thankful.

J H Pitt-Payne

Orthopaedics

Outline of Fractures. 10th edition. J C Adams and D L Hamblen. Published by Churchill Livingstone. Price £15.50

This book is the latest edition of a famous and well established work. It deals with orthopaedic trauma, generally adopting a classical approach and being unimpressed with the fashions that pervade fracture management from decade to decade. It is arranged with sections in large type for the basic medical student and reduced type with greater detail for those seeking honours.

The study of orthopaedics and trauma is only allocated four weeks as things stand in the clinical course, and I feel this book contains too much detail given the limited exposure to clinical orthopaedics on the ward. Bear in mind that if you go with this book you also have to buy the companion book *Outline of Orthopaedics*, by the same authors. A better option would be *The Concise System of Orthopaedics and Trauma*, by A Graham Apley and Louis Solomon, published by Butterworth, which covers the essentials and is excellent at covering the disciplines of examination of the musculoskeletal system.

R N S Slater
Senior Registrar in Orthopaedics

Radiology

An Imaging Atlas of Human Anatomy. Jamie Weir and Peter H Abrahams. Published by Wolfe. Price £19.95

This soft back book is a collection of about 600 images from various imaging techniques to illustrate the anatomy of the regions of the body. There are seven major chapters devoted to the abdomen, pelvis, chest, limbs, the vertebral column and spinal cord as well as the head, neck and brain. The images are of normal subjects using plain radiography, ultrasound, CT, magnetic resonance and angiography as well as some special procedures such as ductography.

The images are of very high quality and with the CT images are small localiser images incorporated into the larger section so that the exact anatomical slice can be determined. The magnetic resonance images are not accompanied by similar localisers and these might be helpful. The magnetic resonance images are predominantly T1 weighted and this is a disadvantage in the brain where numbers are used for anatomical localisation. It is sometimes unclear exactly which structure is being illustrated as the inherent contrast of a T2 weighted image would be much more useful, although perhaps visually not quite as attractive. The images, however, are generally clearly and accurately labelled with numbers referring to the anatomical structures which are then detailed in an accompanying list.

The devotion to keeping the anatomy together does occasionally result in somewhat curious juxtapositions where for example an ultrasound of the carotid artery is placed adjacent to a submandibular sialogram since they are both located in the anterior triangle of the neck. The specific interests of the authors has resulted in the first page of the introduction being devoted to angiography which is slightly unusual for a book intended for medical students but this is presumably related to the alphabetical listing of the techniques illustrated in this book.

These minor criticisms aside, this is an extremely useful book both for medical students and for trainee radiologists and priced at just under £20 represents good value for money if the reader is interested in the radiological techniques involved in anatomical imaging. It also warrants a place in both general and radiological libraries as a reference text.

J B Bingham
Consultant Radiologist

Clinical Radiology in Postgraduate Surgery. M A R Al-Fallouji. Published by Butterworth. Price £35

This book is written by a surgeon to illustrate the use of radiology for surgical management. It is divided into two parts, the first in five chapters covering a general description of the use of radiology followed by a page of examples where the use of radiology may be dangerous, for example in a tension pneumothorax where delay for a radiograph may compromise the safety of the patient. The third and fourth chapters deal with the radiology and treatment of trauma and the fifth chapter deals with the use of radiology in the acute abdomen.

The second, larger part of the book is devoted to 100 clinical cases in a question and answer format to illustrate the appropriate use of radiographs in surgical investigation.

An appendix reproduces the Royal College of Radiologists guidelines on the best use of radiology, published in 1989 which are issued for the use of both hospital doctors and general practitioners.

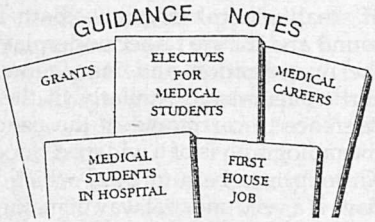
The films, in general, reproduce well and there are a number of line diagrams which are very helpful. It is pleasing to see a surgeon with such a pragmatic approach to radiology, even to the extent of recommending the erect abdominal radiograph only when the supine film has been reviewed and the erect assessed as being necessary. In general, ultrasound is somewhat under represented in the management of surgical patients for example, it is not indicated that ultrasound is the most sensitive technique for the detection of small pleural effusions. Both ultrasound and CT are rather underplayed in the investigation and management of aortic aneurysms. Similarly in the only reference to carcinoma of the pancreas, the radiograph is of a widened duodenal 'C' loop in a barium meal which these days is a very unusual way of making the diagnosis of carcinoma of the pancreas where CT and ultrasound are much more likely to have been used. It is of historical interest that the intravenous cholangiogram is still listed as an investigation for the biliary tree but has been abandoned in most departments because of its high mortality and because the contrast agent is no longer available.

Very few errors in the text have occurred but it is of note that for a small bowel enema the patient would normally lie on the right side rather than the left to facilitate intubation.

Apart from these minor points, this book is clearly written and well illustrated and is certainly worth serious consideration for medical students and house officers seeking a text dedicated to the use of radiology in surgery.

J B Bingham
Consultant Radiologist

BMA



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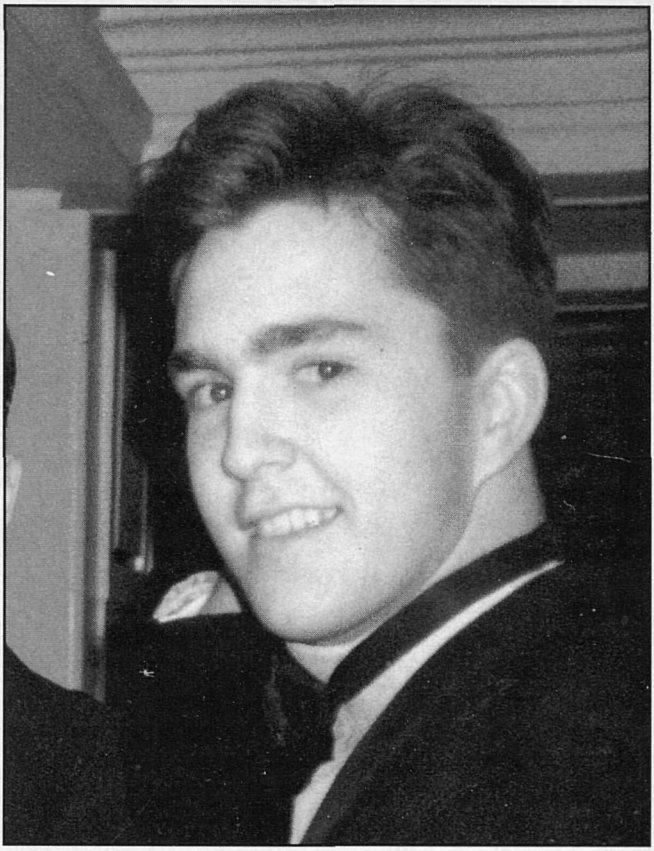
Alexander James Boulger

Alexander James Boulger, born 8 February 1973 and died 16 October 1992; much loved and much missed by all his friends and family, Ray and Lana his parents, his sisters Julia and Victoria and his brother Edward.

Alex's schooling days were shared with me at Reigate Grammar School from the lower sixth onwards. Before that Alex was at Sackville School, where he studied until he completed his GCSEs. At this stage, he already looked forward to the prospect of a dental career.

In September 1989 Alex joined Reigate Grammar school, where he sat his A-levels in Biology, Chemistry and Mathematics. Due to his easy-going and fun loving nature, he fitted in easily and found no problems in making friends. Popularity was something Alex automatically achieved wherever he went. Alex enjoyed his rugby very much at Reigate, being a regular member of the 2nd XV. This team carried the pride of the school in having magnificent results. The closeness and togetherness of the team carried this success to activities after the game. His love and his commitment to the game was rewarded in representing his school in his first tour to the USA and Canada. He enjoyed this so much that it laid down his love for tours thereafter. In saying that, if Alex had to choose his farewell, it would be involved with his two loves, socialising and rugby, and in the name of Guy's Hospital for which he was so patriotic.



Alex was also very musically talented. He spent a lot of time playing the piano for which he achieved Grade 8 standard. Often he modestly showed this talent by playing to his family and friends. His A-level achievements allowed him to pursue his dental training for which he had eagerly awaited.

Alex came to Guy's with the idea of hard work and hard play. He enjoyed his social life to the peak, but not by neglecting his studies. He had the balance between the two measured to perfection. Alex was a regular attender of the bar and all social events, where he inspired all those around him to enjoy themselves. His natural leadership was willingly accepted and appreciated by all his friends. This leadership was illustrated when he was voted the Dental Society Representative for the 1st year. He enjoyed his rugby at Guy's even more than at school. He was a regular member of the 3rd and 4th XV. Both his sporting talent and especially his outgoing nature made him a welcomed character in the rugby club.

Alex will be remembered for his charming, loving nature and his friends received so much warmth from this. Alex will be loved for ever.

Christian Smith

James Hawker

On 16 October, 1992, James tragically died when a minibus carrying members of the Guy's Hospital Rugby Football Club was involved in an accident near Bath. One cannot hope to do justice to a man's life in a few words, particularly to a life lived so much to the full, as James' was.

James arrived at UMDS in the Autumn of 1989 from Millfield School, possessed of an exceptionally friendly, easy-going manner that won him a wide and enduring circle of friends in the medical school as a whole, and in Guy's RFC in particular.

Of greater importance, however, was the relationship that James struck up with Anne Ward on (I believe) the third day of their medical careers! This bond was ultimately to mature into engagement earlier this year, an event met with jubilation by their friends, and with the warm approval by their families.

James loved life at UMDS. His patronage of the bars and his love of a pint eventually formalised with his election as Bar Secretary to St Thomas's this year, and his love of rugby was reflected in his popular and successful captaincy of Guy's RFC 3rd and latterly 2nd XVs.

Academically, James possessed ability that was not given time to come to full fruition. He was nevertheless, a successful student, obtaining a BSc and possessed of that instinctive knowledge of his abilities that enabled him to pass exams without the trauma that others inflicted upon themselves. A sign of a fine mind this.

Above all, James was a loving son to his parents, and loved by his family and fiancé; a loyal and honest friend to all (and there were many) who accepted his friendship. We shall all have many merry and amusing memories of the short time that we were able to spend together. The extent of the deep loss felt throughout the medical school is a true measure of the man.

J R T

Basil P Taylor

Basil Taylor died peacefully in his sleep next to his wife Pamela on 25 September. He had been a staunch supporter of Guy's Hospital all of his working life, and he had made many friends over the years, of both colleagues and patients.

He was at Guy's during the war years when Guy's Dental School was evacuated to Tunbridge Wells. At this time he was very active in all sports especially rugger. On qualifying in November 1940 he went into the Royal Navy and was stationed in Portsmouth, Stockheath Camp Havant and Scotland, and latterly in Ceylon where many adventures were had.

Basil left the RNVR in February 1946 as Surg Lient Cmdr, and became a much respected general dental practitioner at 49 London Road in Tunbridge Wells. He was always keen to try out any new gadgets or technology that was available. His was a familiar face at the meetings and courses held both locally and in London. He was also one of the founder members of the Dental Society of London which he attended regularly up to two years ago, and was president of in 1978-79. He retired to his country house to play with engines and making exact 1/12 scale miniature furniture replicas, including the dove tail joints and all in 1991.

He married Pamela in February 1943, and they had a loving happy marriage, never being apart for even one night from the day he left the services. There were two children Julian Taylor who sadly predeceased Basil, and Coryn Taylor. Both were enthused by Basil's love of dentistry, science, and fast cars, and as a result followed him into the profession also training at Guy's, and later became partners with Basil at 49 London Road.

Basil's is a great loss to all and will be missed by many, but especially by his wife, daughter and two grandchildren.

C P Taylor

Ivor Hilliam

Ivor Hilliam died on 9 October at the age of 69. He was born in Leeds in 1922 and a Yorkshireman he remained, despite moving to the South in 1930. He was educated at Queen Elizabeth's Grammar School, Wimborne, Dorset, and entered Guy's Dental School in 1941. He qualified in 1945 and after a House Surgeon appointment under Prof Fenn, completed his National Service in the Royal Navy. On leaving the RN in 1948, Ivor joined the practice of W G Daniels in Bournemouth as an Assistant. Three years later he formed a partnership with his brother which lasted for 15 years. Ivor's career in dentistry ended abruptly in 1978 when the pressures and increasing chaos of the NHS made him one of its casualties.

Ivor's life and character were many-sided. Imposing in stature and unmistakable with moustache and sonorous voice, he was a gregarious and striking figure. Yet he was a private man; not a joiner of committees and organisations, though in his time he served on both. In many ways his life with Mary, whom he married in 1953, and the family, was kept private. For Ivor, 'home was his sanctuary', with his love for Mary and his pride in and love for Mark their son.

But there was life at the surgery, with Ivor's meticulous care of his patients. Educated and qualified before 1948 Ivor was unwilling to compromise one iota the standards and ideals with which he

entered upon his career, and many were—and still are—grateful for his kind and caring attention.

Of all the aspects of Ivor's character, it was his involvement in sport which was to touch and inspire so many. It was in the Centenary Year of Guy's Rugby Club that Ivor started playing for the 1st XV and towards the end of the following season, on the resignation of R G L Brittain because of hospital duties, Ivor was elected to succeed him as Captain for the remainder of that season, and for the following one which saw the post-war revival of the Hospital Cup, the final of which against St Mary's was played in the presence of the King and Queen. In the Navy Ivor played for United Services Portsmouth and was awarded his Honours Cap in 1947.

On returning to Bournemouth, Ivor embarked upon a long love affair with rugger in East Dorset. He was a founder member of Wimborne Rugby Club to whom he is and always will be a legend. As a player he played with distinction and always led the pack with ferocious intensity which scared his own side let alone the opposition. He was a born leader on and off the field, and the Club House was his cathedral where many learned from him the right values in life—work hard, play hard, and drink a few beers! 'You never get anything in life without working for it' he would say. Everyone had to pull his weight, and of course push more than his weight.

In later years his interest turned to golf where he was a member and great supporter of Ashley Wood Golf Club. It was a frustrating game for him at first, but as much as anyone ever does, he mastered it in the end. Golf, gardening, Jason his dog and the occasional pint—filled his time. Wellington boots were the dress of the day.

The last 18 months have been difficult and painful for both Ivor and Mary. No longer the golf, and fewer walks with Jason, but he never gave in to pain and he never lost his sense of humour. Within hours of the end and still refusing pain relief the spark still broke through, and he would have enjoyed the service at Poole Crematorium where the singing was Rugger Club style—full-throated, and where much of this appreciation of his life was read by the Reverend Prebendary Michael Bartlett, to whom I am indebted for permitting my quoting it.

A W Hilliam

Classifieds and Announcements

The *Gazette* is pleased to publish classified advertisements. These are charged at the rate of 10 pence per word—money with order please. It is helpful if you can include a contact telephone number in case of any queries.

Announcements of births, deaths and changes of address will be published free of charge.

South African War Memorial

Readers maybe interested to know that work will start shortly on the restoration of the statues of Thomas Guy and Lord Nuffield and the South African War Memorial on the Counting House wall of Guy's House.

The Thomas Guy statue is made of 'Dutch Metal', and alloy of copper and zinc. It was commissioned for the Hospital in 1732 from Peter Scheemaker, a notable sculptor, for the sum of 500 guineas. Dr Richard Mead and Charles Joye, then the Treasurer of St Thomas's and Guy's were two of his principal patrons. When Charles Joye died in 1738 he left a further 500 guineas for Scheemaker to make another statue—of King Edward VI—for St Thomas's Hospital.

Thomas Guy's statue was last cleaned at the time of the Hospital's 250th birthday celebrations in 1976. Those who have looked closely at it recently will realise that it is again deteriorating, mainly from the effect of sulphur in the atmosphere.

The Hospital is indebted to the Heritage of London Trust for a donation to cover the cost of this work.

The Lord Nuffield statue was erected in 1948. An old cine film of the unveiling of this statue has been discovered, together with a number of other classic clips of Guy's in wartime. We hope shortly to assemble these into a video for sale to those interested in the history of Guy's.

Professor Richard Hughes writes about the South African War Memorial as follows:

Next time you walk from the front quadrangle through the colonnade spare a glance to the left at the faded masonry fountain on the wall outside the Unit Manager's Office. This is the South African War Memorial. It caught my eye when I first arrived as a medical student because the last name on the roll of honour was my great-uncle, Lawson Jervis Hughes. He was only 22 years old when he died, a medical student who in the excitement of the hour had joined the splendidly-named 14th Battalion Imperial Yeomanry as a mounted medical orderly (Figure 1).

Figure 1: Lawson Jervis Hughes in the uniform of the 14th Battalion Imperial Yeomanry.

The *Guy's Hospital Gazette* earlier in 1900 had listed about 20 Guy's doctors and medical students already serving in the South African War. Photographs illustrated the lines of tents of the regimental field hospital, neatly pitched before low mountains on the veld. The doctors and nurses had to contend with the ravages of enteric (typhoid) fever and fearsome gunshot wounds These accounts and the patriotism which Queen and Empire then inspired would have attracted an adventurous young man like Lawson. I suspect that many a modern medical student who now spends an elective in Zimbabwe or South America would have been on the next boat to Capetown if they had been at Guy's 90 years ago.

For Lawson the excitement came to a sudden end on 11 June 1900. The details are not clear but the field hospital was overrun by the Boers. Lawson, who was unarmed, refused to surrender and was shot dead.

His obituary in the *Gazette* of 7 July 1900 records that he was a 'very keen sportsman, and an enthusiastically patriotic supporter of Guy's'. The obituary goes onto offer the consolation that he 'met his death in the happiest way', dying 'by the swift bullet and not by wasting disease'. While that sentiment has some truth, the blow to his parents must have been bitter. His father, who had trained at Guy's and was a general surgeon practitioner in Plymouth, was to lose another son in the Great War. However, even as Lawson died there was yet another son, E C Hughes, affectionately known as 'Joey', waiting to come up to Guy's as a medical student and go on to become senior surgeon to the hospital. Joey lived through two World Wars, in which older readers may have served, or may remember the second. Happily, for the last two generations, most Guy's men and women have been spared direct involvement in the horror of war. For us therefore the War Memorial is a sad but beautiful reminder of brave souls untimely lost, and a warning to future generations to conduct our foreign affairs in a peaceable fashion; a lesson from history which we repeatedly fail to learn.

The committee of the *Guy's Hospital Gazette* is to be congratulated on having taken the initiative in raising subscriptions for a memorial to the Guy's men who had died in the South African War and deciding on its nature (Passim, 27 October 1900). The issues of the next two years are filled with lists of subscriptions from staff and students ranging from several guineas to half crowns and letters suggesting the form and site of the proposed memorial. Times have not changed since Lawson's father felt impelled to write, 'I hope the memorial will not be placed in the chapel, which in my time was rarely visited by students, but will take the form of a monument in the park or a stained glass window in the hall.' The design and site of the monument were hotly debated in the correspondence columns and committee meetings of the *Gazette*. Eventually a drinking fountain was commissioned for the sum of £250 from Mr Frederick Wheeler FRIBA. The work was undertaken by Coalbrookdale Company and John Daymond and Son. It was placed in the Colonnade were it still stands, close to the entrance of what was then Astley Cooper ward. At a ceremony on Friday 3 July 1903 Dr Frederick Taylor, Chairman of the Memorial Committee, invited General Sir Richard Harrison, GCB CMG, to unveil the memorial. The memorial was a beautiful drinking foun-

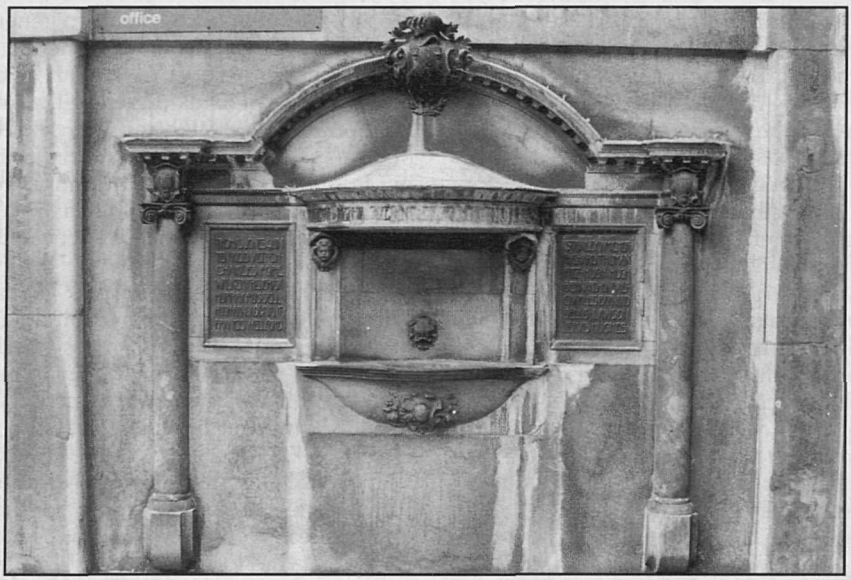


Figure 2: The South African War Memorial

tain made of coloured and polished marble with the inscriptions picked out in bronze (Figure 2):

To the Guy's Men who died in the South African War. 1899-1902. *Ante Diem Perierunt Sed Militantes Sed Pro Patria*

(They died before their time, but they died fighting, fighting for their country).

The names of those who died were commemorated in bronze plaques flanking the fountain. The General made a short speech listing those who died, some having been shot and others dying from typhoid (Table 1). He finished his speech by asking the Treasurer of the Governors of Guy's Hospital to take charge of the beautiful memorial, and 'keep it for ever'. The Treasurer, Mr Cosmo Bonsor, undertook on behalf of the Governors of the Hospital to hold the memorial in trust for ever and to minute the proceedings in the next Court of Governors 'so that no doubt may ever arise as to the intention or the nature of the trust which I now accept on behalf of the Governors.' The reverent gathering then walked down the Colonnade steps into the chapel for a service. I am sure that on that occasion the chapel will have been overflowing, and that Lawson's father will have travelled up from Plymouth on the Great Western Railway to be there, with Lawson's younger brother, Joey, who was by now a surgical ward clerk.

Time has dulled the masonry of the memorial and some of the bronze letters have been shed with the passage of the years. Sadder still, the polished marble, which was once a major feature of the Memorial, has disappeared (Figure 3).

We are fortunate that English Heritage has promised to help the Hospital to honour its trust and refurbish the memorial, which will once again adorn Guy's House and bring to mind those brave young men who died fighting in South Africa 90 years ago.

Figure 3: The polished marble surround that used to adorn the memorial

- Thomas Jones—Superintendent of the Welsh Army Hospital. Died at Springfontein.
- Quintin Reid Veitch—Major Cape Medical Staff Corps. Died at Cape Town.
- Charles Pope Walker—Major Royal Army Medical Corps. Died in Ladysmith during siege.
- Frederick Murray Russell—Captain New Zealand Contingent. Killed in action at Rhenoster Kop.
- Hugh Arnold Bryant—Civil Surgeon. Died at Bloomfontein.
- Francis Wellford—Surgeon-Captain 7th Imperial Yeomanry. Died of wounds received at the Battle of Vlakfontein.
- Stanley Whicher—Civil Surgeon Natal Field Force. Died at Mooi River.
- Richard Truman Fitz-Hugh—Civil Surgeon attached to Imperial Yeomanry Hospital, Deelfontein. Died there.
- Hugh Bernard-Onraet—Lieutenant Royal Army Medical Corps. Killed at the Battle of Pieter's Hill before the Relief of Ladysmith.
- Charles Bernard Sells—Surgical Assistant at the Imperial Yeomanry Hospital, Deelfontein, where he died.
- Lawson Jervis Hughes—Mounted Medical Orderly Imperial Yeomanry Field Hospital, killed in action at Kroonstad, on refusing to surrender.

Table 1: The names of those commemorated on the South African War Memorial

Every dog has his day

Nurses must be aware that the Tomlinson Report arrived in late October and has considerable implications for them and the hospital in which they work. One emphasis of Tomlinson is the improvement of local primary and community health services This means deployment of trained nurses from within the hospital to work outside in clinics and patients' homes.

The Guy's Trust warmly welcomes the merger of Guy's Hospital with St Thomas's Hospital on one site as soon as possible. Tomlinson recommended a single management structure for Guy's and St Thomas's to be created and a joint Trust established from next April, with the closure of one site within two years. The Trust intend to keep staff informed of developments, especially on speculation about redundancies. One newspaper commented that consultants over 50 would rush forward to snap up redundancy pay-offs up to £200,000. What can nurses earning much less expect to gain in this lottery? Lewisham is to be returned to its own locality—from whence we borrowed it some years ago, and become a Trust in its own right.

The first issue of the *Bridge*, newspaper of the soon-to-be-defunct Guy's and Lewisham Trust appeared just before Tomlinson. It says little about nurses, but since whatever happens to our hospital affects the nurses in it, it is relevant to hear what it says. It suggested that hints about Tomlinson's contents had been met by an 'unnatural peace' from our Trust. It added that Guy's Management Board recognized that Guy's and St Thomas's 'must go forward as partners'. Its mole asked how this would take place, likening it to the answer to the question of 'how do hedgehogs make love?...very carefully!'

But readers of this journal may not be so aware of the reaction at St Thomas's. Its chief executive is reported as commenting on Tomlinson that: 'it is totally unrealistic to assume you could have a merger within two years....unrealistic and woefully short of analysis... completely untested assumptions about the primary health care system—health service centres within the community—which could replace the closed hospital'.

In the light of this he questioned the London Ambulance Service's ability to transport patients greater distances. This view is enhanced by revelations about London Ambulance's failure to ensure its '999' targets. Does the '999' call really get an answerphone reply? And has anyone asked the people of the Borough, whose hospital this is, what they think? If their views are to be judged by ballot-box activity, few of them expect politicians of any persuasion to solve problems relating to the NHS, or much else: in Southwark nearly 40% did not vote at the last General Election, and in nearby Peckham the figure was nearer 50%. One needs little power at crystal-ball gazing to see the two-finger brigade's opinion of Tomlinson.

No wonder, the new paper is called the *Bridge*: although the medical and nursing schools have both been amalgamated for a few years, the service side of each hospital certainly needs a 'bridge' if there is to be a unity. The views of each seem dissonant. Nevertheless they have subsequently indicated they intend to speak with one voice.

Our own chief executive points to the links between the two hospitals over the past two centuries. Guy's started a medical school in 1825 and a nursing school in 1880. Only 16 years before that St Thomas's had left its site 'over the road' so that the South Eastern Railway could extend from London Bridge to Charing Cross. It was only a little earlier, in 1842, that St Thomas's had sought to re-unite with Guy's medical school. So, it has been in and out, before! 150 years on it looks as though the merger of all aspects of training and care will take place.

Mrs Bottomley, quoting from Tomlinson on the day it appeared, once referred to its author as 'St Bernard', prematurely, and probably mistakenly, canonizing Sir Bernard. In further canine indulgence it sounds as though St Thomas's had a rottweiller speaking for it initially, in contrast to the rather subsidiary poodle here. Still, I suppose every dog has its day, and maybe the latter's intelligence will prevail. As nurses, we must hope so.

Denis Cobell

Saudi physiotherapy

The junior physiotherapy staff rotate four monthly through the specialities to gain a wide experience in the two years immediately post-registration. In the past year they have had the opportunity to choose a position in the King Fahad Military Hospital in Khamis Mushayt. Jane Carpenter is one of the four who have made the journey and as she is planning to return at the next change-over, shares with us the following piece.

By the time I finally set foot in Saudi Arabia my arrival had been postponed so many times that I had become used to the idea of being a permanent fixture on Esther Ward, endlessly consuming cakes on Dr Knight's Wednesday ward rounds. I'm sure he thought I stayed for the doughnuts, but in fact the Saudi Embassy had ground to a halt during Ramadan and the visa was not forthcoming.

Until we reached the hospital site it all seemed very foreign; the men in their *thobes* and *githras* and the women faceless, completely veiled from head to foot. The landscape was barren and littered with debris and not very much like Southwark. The compound on King Fahad Military Hospital is peopled with ex-pats, and quite a home from home, though.

The staff are predominantly British, Irish, Australian, New Zealanders and Scandinavian, with English as the work-

ing language. I learned Arabic along the way, but such gems as 'lift your leg high' and 'do you have pins and needles?' do nothing for you when haggling for a pound of tomatoes in the soukh. Interpreters are readily available to work closely with you if necessary, throughout the hospital.

The working atmosphere was pleasant and quite relaxed, even if all the women suffer from low back pain due to obesity and the after-effects of 14 children, and the men turn up a fortnight late for an appointment demanding to be seen within 10 minutes. Communication is only one aspect of a different approach to treatment. It is impossible, in a physiotherapy department at least, to obtain the same results with 'Western medicine' without the full understanding and co-operation of the patient. Flexibility is essential in devising suitable treatments and one needs to be willing to find common ground. This does not extend to including traditional methods such as burning the flesh with hot nails, however.

Apart from these professional-client relationships, there is virtually no social contact with the Saudis, although a few are employed in the department as technicians. Due to the strict law, this is perhaps easier (although less interesting) for all concerned, especially for the *muttawas* or religious police. This makes for an almost medieval social structure, in which beheadings and other such punishments are still a part of life.

However, the restrictions (mainly upon women), do not limit the social life to a great extent; discretion being the key word. The single paramedical staff live mainly on one compound site, which has facilities including tennis courts and outdoor pools, recreation centres mainly around bars (unofficially) and sports (officially), including diving. The Red Sea reefs are spectacular and untouched by tourism. Having never even snorkelled before, I felt like Jacques Cousteau and even the leering locals failed to dampen my enthusiasm.

In conclusion, I am returning in November for another four months in the land of Mohammed. Don't send me any Christmas cards!

Jane Carpenter

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Rugby Club

Guy's 3rds v Bec Old Boys. 7 November. Won 75-0.

A glorious day for Guy's 3rds. Despite being a player short on the wing we arrived at Bec Old Boys' grounds with high hopes. In the first five minutes of the game we failed to convert our dominance into points. Scotty received a cut above the eye and needed to leave the field for minor treatment. So with 13 men we began to turn the taps on. By half time we had accumulated 54 points. However after half time Bec O B brought on a 1st team substitute who gave them some courage and allowed no entry for us for 20 minutes. However, relentlessly, Guy's pressure destroyed the morale of the opposition, and again tries came thick and fast.

Among the try-scorers were: Ugo, John Murphy, Mark Morgan, Kier Lewis, Pit Pony, Scanners and Peter Goodyear.

A total of 11 tries were scored, 10 of which were converted by fly half Kier Lewis. With such talent and commitment in the 3rd team and five teams playing every Saturday it must make Guy's RFC the largest and strongest medical school side in the country!

Team: Mic Martin, Mark Morgan, Kev Smith, Rich Dales (capt), Richard Stratton, Scotty, Stew Livingstone, Pit Pony, Kier Lewis, Peter Goodyear, Paul Scanlan, Ugo , Keith Underwood, John Murphy.

London Irish B2s v Guy's 3rds. Won 22-15.

On the sunny Saturday afternoon of 31 October at Honor Oak Park the 3rds played their closest game of the season so far. The Irish opened their account with a drop goal to which, to everyone's surprise, Guy's immediately replied with an identical drop goal from the boot of Peter Goodyear at fly half. A good period of Guy's pressure then followed and a great drive from the front five allowed Richard Dales to go over at No 8 for a push-over try. Peter Goodyear converted the try. Irish, with great mauling play immediately came back at us with a try close to the posts which was converted. The scores at half-time are 10-10.

In the 2nd half Guy's lineouts improved and James Thallon and Pat Davis gave us the ball to allow the backs to bring us up into the Irish half. An opposition infringement gave us a penalty on their goal line. A scrum was opted for and despite a great drive from 2nd rows Nick Hennessy and James Thallon, the Irish held firm. However, a quick ball flicked from No 8 allowed Jamie Coombes at scrum half to go over in the corner for an Underwood-like try. The Irish responded with another try which was also unconverted allowing the scores to remain even at 15-15. With five minutes to go, the game looked set to be a draw. However some lightning running by Keith Underwood on the wing put us up in the Irish 22 and good 2nd phase ball allowed centre Christian to go over, scoring the winning try.

Team: Kev Smith, Cris Howell, Ken Ivil, Nick Hennessy, James Thallon, Richard Dales (capt) , Stew Livingstone, Pat Davis, James Coombes, Peter Goodyear, Paul Scanlan, Christian, Scotty, Keith Underwood.

Deaths

GILCHRIST, Kenneth James died after a short illness on 23 October aged 82. A graduate from Guy's of 1932, he had served as Principal of the Fiji School of Medicine until his retirement in 1970. According to his wishes, he was privately cremated in Fiji.

KIRBY, John Vernon, a retired general practitioner died on 27 October 1992. He qualified in 1947 and spent 33 years in practice in Kimbolton, Cambridgeshire. He leaves a wife, two daughters and a son.

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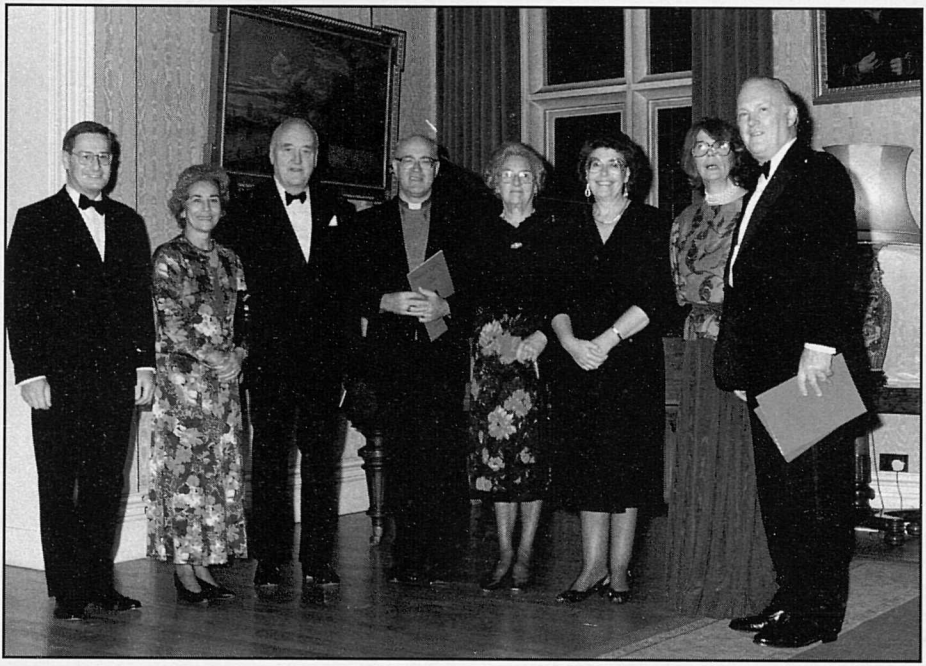

Professor Chantler, Principal of UMDS and Mrs Chantler joined Lord Whitelaw, Chairman of the Living Image Appeal and the Archbishop of Canterbury for the Charity performance at Lambeth Palace. Standing next to Dr Carey from left to right are Lady Whitelaw, Mrs Carey, Mr and Mrs Murray. Mr Murray represented R J Kiln & Co, underwriting agents at Lloyds who organised the event in recognition of £200,000 response from the Lloyds market to the appeal for the PET Clinical Centre.

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